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# Haitian Women's Role in Sexual Decision-Making: The Gap Between AIDS Knowledge and Behavior Change

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## Executive Summary

As the HIV/AIDS epidemic in Haiti accelerates, HIV sero-prevalence studies report increasing risk among women in the general population. In a national AIDS KAPB study in 1989, women reported fewer multiple-partner relationships than did male respondents and were reasonably well informed on AIDS prevention, yet they expressed significant fear of acquiring the disease. These and other studies suggest that Haitian women's capacity to negotiate safe sexual behavior, including the use of condoms, may be related less to their knowledge of the disease than to their customary role in the sexual relationship.

This qualitative study used the focus group method to explore perceptions concerning norms that govern sexual decision-making and behavior associated with the risk of HIV transmission to women. The emphasis is primarily on the role of women in the sexual relationship, particularly with respect to their potential for initiating behavior change, and secondarily on the perspectives of men on issues which determine women's rights to protect themselves. Trained moderators conducted discussions with twelve groups of women and six groups of men at research sites in Port-au-Prince and Les Cayes. A loosely structured discussion guide focused on (1) knowledge of HIV/AIDS transmission and prevention, (2) sense of personal vulnerability, (3) perceived consequences of AIDS, (4) household decision-making, (5) sexual decisions and women's rights, (6) communication with sexual partners about behavior change, (7) discussion of AIDS with other women, and (8) counseling adolescents about HIV/AIDS prevention.

Principal findings follow:

- Both male and female participants were well aware of the heterosexual nature of AIDS, but many held inaccurate or distorted views of other modes of transmission, citing various examples of casual contact. There appeared to be little understanding of the danger of perinatal transmission.
- Women expressed keen awareness of the severity of AIDS and of the susceptibility of people like themselves. Of particular concern to them was their realization that AIDS destroys families and leaves children destitute.
- Gender distinctions in household decision-making give women responsibility for domestic maintenance and men control over economic resources and sexual freedom outside as well as inside the home. Women who have no earning power were seen as receiving little respect and having little influence on household decisions and sexual negotiation.
- The high value women attach to harmony in long-term unions leads them to condone or overlook a man's sexual activity outside the home in the interest of protecting the partnership.
- The protection that condoms offer against HIV transmission was common knowledge, but many women associated condoms with (a) risk of female genital disease and (b) admission of infidelity or HIV infection.
- Male participants were more likely than women to believe that men would agree to use condoms, but both tended to put the onus on women to convince their partners via demonstrations of affection and tactful persuasion.

- Women (more often than men) advised that a woman should refrain from sex of any kind with a promiscuous partner or even abandon him if she could not convince him to be faithful to her. At the same time, women and men acknowledged the risk to women of male retaliation and loss of financial support if she takes that step.
- A woman's refusal to engage in sex was believed by both women and men to increase her risk of acquiring HIV by encouraging the man to seek other partners "on the street." Men, and to a lesser extent women, often advised women to increase their sexual activity with a promiscuous partner as a strategy to distract him from other women and keep him at home.
- Women expressed a strong sense of responsibility for counseling sexually-active children to protect themselves from AIDS but doubted that young people would comply. Other than to provide stern warnings about the disease and the harshness of life in general, they offered few ideas for influencing adolescent sexual behavior. When prompted, the majority agreed that adults should advise adolescents to use condoms, though some vigorously disagreed.
- Women also felt responsible for advising other women to protect themselves from HIV by negotiating safe sexual practices with promiscuous partners or altering their own risky behavior. However, some feared that such advice might be interpreted as slanderous in intent, aimed at defaming character or destroying a friend's relationship.

The findings of this study point to an urgent need to intervene in the advancing HIV/AIDS epidemic at the level of behavioral norms and expectations which currently deny most Haitian women the right to protect themselves and their families from the disease. The authors of this report, therefore, propose an approach to AIDS intervention which emphasizes increased participation of women in developing and implementing prevention strategies; use of focus groups to promote dialogue and conflict resolution between women and men; design of mass media messages that emphasize the right and responsibility of women as well as men to protect health; and programs which enable adults and adolescents to collaborate on AIDS prevention initiatives for young people. To help reverse the prevailing negative image of condoms, AIDS prevention programs must also ensure not only that condoms are readily accessible but that users can be confident of their quality.

Finally, the authors identify new questions and issues which have emerged from the study. They propose additional avenues for research which they believe would lead to greater understanding of the dynamics of sexual behavior change to reduce the risk of HIV transmission.

## **I. BACKGROUND**

### ***1.1 Introduction***

This research explores the gap between knowledge of the acquired immune deficiency syndrome (AIDS) and behavior change in Haiti, examining a variety of perspectives on the roles that women play in sexual decision-making. Prevalence of the human immunodeficiency virus (HIV) in Haiti now has reached a level which warrants preventive action outside currently targeted high-risk groups. The epidemic in this country has shifted from prostitutes and their male clients to the spouses and partners of infected men in the general population. The risk to women is accentuated by the fact that the norms of family life for the disadvantaged Haitian majority predispose men, more than women, to seek other partners in various unions outside the primary relationship. Moreover, as the more stable parents in the lives of many children, women are the teachers and role-models of sexual responsibility for countless adolescents who probably constitute the most vulnerable population of all.

The work focuses primarily on norms and expectations of sexual behavior and on communication as a means to reduce behavioral risk, emphasizing in particular the capacity of Haitian women to initiate or negotiate behavior that will reduce the risk of HIV transmission in the general population. It particularly highlights the perspectives of women, comparing them with male views on many of the same AIDS-related issues. A goal of the study is to provide information which will help AIDS control programs in Haiti to strengthen the capacity of women to act as change agents in their own sexual relationships as well as in their families and wider community networks.

The study was designed in collaboration with the Haitian Child Health Institute (CHI) and with the participation of an advisory committee comprised of representatives from ten non-governmental organizations concerned with AIDS intervention and control in Haiti. The Principal Investigator was Dr. Priscilla R. Ulin, a medical sociologist and Behavioral Research Fellow at AIDSTECH/Family Health International. Co-Investigator was Dr. Michel Cayemittes, a public health physician and Director of the Child Health Institute. Research Assistant was Elisabeth Metellus, also of the Child Health Institute. Members of this team contributed to the development and implementation of the project from a variety of complementary perspectives. The Advisory Committee helped to develop the research objectives and refine the focus group guidelines. Data were collected in Haiti in April and May 1992.

### **Trends in HIV Prevalence in Haiti**

The changing pattern and prevalence of HIV infection in Haiti underscore the urgency of developing AIDS prevention strategies which target women in the general population. The first case of AIDS among Haitians occurred as early as 1979 (1). Since then, in a population of 6,287,000, the number of reported cases has climbed to over 5,000 with an increase of 100 percent between 1989 and 1992 (2). Estimated HIV prevalence in urban groups in Haiti such as prostitutes and their clients, STD patients, and others with known risk factors has been estimated at around 42 percent (3), while urban and rural Haitians with no known risk factors are believed to be infected at rates of 9 and 5 percent respectively (3).

Reports of cases among males outnumbered females in the early years, but today the numbers are about equal, reflecting a significant increase in heterosexual transmission. Diagnosis of sexually transmitted disease and having a spouse infected with AIDS have replaced blood transfusion, unsterilized needles, and prostitution as the primary factors for HIV infection among women, who are at great risk of contracting HIV from infected partners. A Cornell-GHESKIO study of 119 HIV-discordant couples in Port-au-Prince demonstrated a sero-conversion rate of 14 percent in a mean period of 17 months, with approximately equal proportions of men and women becoming infected (4). In a similar sample, the same researchers reported that pregnancy occurred in 25 percent of discordant and 27 percent of concordant couples, striking evidence of the risk to children of infected women (5). Later studies by the Cornell-GHESKIO group, however, found lower pregnancy rates following intensive individual counseling (6).

Various studies of pregnant women from presumably healthy populations in Port-au-Prince have uncovered seroprevalence rates between 7 and 10 percent (7) and recently 16 percent of the mothers in a sample of hospitalized infants were found to be HIV-infected (6). A national survey of 1,245 postpartal patients in Haiti found evidence of HIV in 7.3 percent of urban and 1.9 percent of rural women in the sample (8). On the basis of their findings, the authors of this report conclude that approximately 70,000 sero-positive women in Haiti will give birth to between 2,800 and 4,500 HIV-infected infants a year, or an average of 8 to 12 new cases each day.

### **The Child Health Institute KAPB Study**

Most Haitians are now aware of the risks and consequences of AIDS. In 1991, the Haitian Child Health Institute reported findings from a national survey of AIDS knowledge, attitudes, beliefs, and practices (KAPB) that documented the wide discrepancy between knowledge of the disease and preventive behavior (9). Although few of the 2600 men and women in the sample had ever seen a case of AIDS, 98.5 percent knew of the disease, and almost 61 percent could link it with sexual transmission. Women were generally better informed than men and less likely to report sexual behavior associated with risk of infection. Two hundred and eighty men (21.5%) in contrast to 19 women (1.5%) admitted to having sexual partners outside a "regular" relationship in the month preceding the survey. These figures may underestimate the actual risk of infection for both men and women, but the gender difference is striking. Seventy-eight percent of the women knew that AIDS can be prevented, but despite their relatively low reported risk and their knowledge of preventive measures, 41 percent still believed they, themselves, were at risk of acquiring the disease.

### **Family Structure and Sexual Negotiation**

The discrepancy between reported behavior and perceived personal risk among women can not be explained in the context of the KAPB survey. Under-reporting of "outside" sexual partners may contribute to the difference, but another factor may be women's awareness of their husbands' extramarital unions and the risk that this behavior poses for their own health. The extent to which women perceive themselves to be passive recipients of a fatal yet preventable disease is a key issue that has shaped the design of this research. Coupled with evidence of

rising HIV-prevalence among low-risk women, it is an issue to be taken seriously in the search for more effective means to motivate behavior change. If AIDS prevention measures, specifically condom use and partner reduction, are largely under the control of men, then how can intervention programs help women exercise more control in behavior change decisions?

Multiple partner liaisons are common in Haiti, but their full extent is not known. Boulos et al. citing J. Coreil note that it is common for urban men to have more than one sexual relationship and more common among men than women (1). Anthropological studies of family structure and conjugal relations have documented sexual mobility in a complex typology of sexual unions that reflects historical and socioeconomic realities of the country. The most binding, but by no means the most common, form of such unions is the legal institution of marriage (*maryaj*). Since the costs of civil and religious ceremonies and attendant celebrations are beyond the means of most Haitians, a practical and more usual solution is a common law relationship known in Creole as *plasaj*. To be *plasé* is to accept the expectations and responsibilities of a long-term relationship without the prohibitive cost of a marriage ceremony. Cohabitation in *plasaj* is the norm, and the rules of economic exchange for domestic service apply as they do in a marriage relationship though without the force of legal sanctions. Unlike the *maryaj* and *plasaj* forms, other unions (*vivavek*, *ménaj*, *rinmin*, *flansé*, *tizammi*) do not imply long-term commitment and carry no more than loose responsibility, if any, for economic support and well-being. Couples in these relationships customarily live separately (10, 11). In the present study, variation in types of sexual union is important because of their potential to accelerate the advance of the AIDS epidemic by encouraging multiple partnerships and diminishing personal responsibility for the mutual protection of health. At any one time, most adult Haitians have some type of stable relationship, but the proportion who simultaneously maintain other unions is unknown.

Lowenthal (11) describes the conjugal relationship in rural Haiti in terms of confrontation and exchange of resources in a "field of competition" between men and women. Men depend on women for domestic labor and reciprocate by providing material support in a long-term relationship. In Lowenthal's analysis, the public ideology that governs sexuality puts men at a disadvantage by supporting the notion that sex as a medium of exchange is valued by men but not by women. As long as women can claim not to want what men can offer, they have a theoretical advantage in negotiating access to sexual services. Lowenthal observed that, privately and among themselves, women acknowledge their desire for sex but for bargaining purposes choose to maintain the appearance that sex is an unwelcome burden.

Although women in Lowenthal's study had the upper hand in sexual negotiation, they had significantly less influence on the physical encounter itself. Once in the sexual act, men assumed the dominant role in relation to female partners, who, according to Lowenthal, tended to be viewed as objects in the transaction. The juxtaposition of roles in the two arenas is fundamental to the double standard of sexual conduct that holds women responsible for the conditions under which a sexual encounter takes place and exempts men on the grounds that they are less able to control their desires and therefore are rarely accountable for their sexual exploits.

If, as Lowenthal's work suggests, women are accustomed to negotiating sexual relations to promote their own welfare but have little influence in their partners' other sexual affairs, perhaps they have merely looked the other way when their husbands disappear from the house without explanation, accepting the belief in men's greater need for sexual gratification and

maybe at the same time feeling free to pursue their own sexual agendas. This pattern of behavior may actually have been functional for the stability of the union, but today it is fuel for the AIDS epidemic.

Efforts to change sexual behavior in response to the threat of a new and sometimes poorly understood disease are likely to meet with resistance. As long as monogamy and male condoms are the only available means to prevent HIV infection, the woman's bargaining position will be weak. If the male partner is unable or unwilling to exercise restraint or accept protection, traditional resources available to women may be inadequate for negotiating the transition to new norms of sexual behavior. On the other hand, the contractual nature of male-female relationships in Haiti may prove to be the basis for such negotiation if there is common understanding of AIDS and mutual interest in protecting the lives of the couple and the family.

## ***1.2 Research Problem and Objectives***

### **Overview**

This study addresses problems of communication and influence in sexual decisions that affect the risk of HIV transmission. Its primary purpose is to explore prevailing norms and the capacity of Haitian women to negotiate sexual behavior change with their male partners as well as their ability to disseminate AIDS prevention messages to others. The research also explores male perspectives on AIDS prevention and on the role of women in sexual decision-making. As applied research, it seeks to identify new strategies for involving women more effectively in efforts to slow the spread of the AIDS epidemic in Haiti.

### **Study Objectives**

1. To establish the knowledge base of study participants concerning (a) AIDS transmission, (b) modes of prevention, and (c) sources of information.
2. To identify women's understanding of the seriousness of HIV infection and their attitudes concerning personal vulnerability.
3. To examine women's perceptions of the norms that govern sexual decision-making and behavior associated with the risk of HIV/AIDS.
4. To assess women's belief in their own power to control the sexual relationship.
5. To explore women's sense of responsibility for promoting AIDS prevention among adolescent children.
6. To assess women's motivation to promote sexual behavior change through interaction with other women.

7. To explore male-female differences with respect to (a) norms of sexual decision-making and (b) sense of responsibility for protecting themselves and others.
8. To identify factors that may promote or hinder women's ability to influence sexual behavior.
9. To identify possible intervention points for strengthening the role of women in the prevention of AIDS.

### ***1.3 The Focus Group Method***

Focus groups are often used in conjunction with other research methods, but in the study presented here they served as the principal means of data collection. The Child Health Institute's KAPB Study (9) had established a base of quantitative information on AIDS knowledge, attitudes, beliefs, and practices of 2600 Haitian men and women. The authors of the KAPB report raised a number of critical issues that would be difficult to address in the highly structured format of survey design. The present study both validates and builds on KAPB survey findings with respect to the particular vulnerability of women in sexual relationships. Whereas the KAPB survey reported individual attitudes and behaviors, the focus group study explores group norms and expectations of behavior. The latter approach widens the search for clues to the knowledge-behavior gap by examining the social context of behavior as a backdrop for individual decision-making. Responses to questions about how people define risk and what they expect from the behavior of sexual partners lead to a deeper understanding of barriers to behavior change. How do men and women divide responsibility and authority for common household decisions? How does sexual decision-making compare with decisions that men and women make in other domains? Who initiates sexual activity? To what extent do women have the ability, the right, or the obligation to resist the sexual advances of men, particularly when they fear that their partners may infect them with the AIDS virus?

Focus group data do not permit quantification of these issues nor generalization to a larger population. However, they do reveal relatively spontaneous reactions to common problems and events in the lives of the participants. Rather than ask how many people use condoms, the focus group discussion probes the meaning of condom use, how women feel about raising the issue with a partner, and what response they might anticipate were they to do so. Although the moderators for the most part avoided direct questions about personal behavior, participants tended to identify with the discussion to such a degree that they often used themselves as examples to illustrate their points or explain their opinions on a topic. The richness of their expression in spontaneous dialogue with peers offers clues to understanding the ways that Haitian men and women communicate on delicate issues that have now become matters of life and death.

## **1.4 Research Procedures**

### **1.4.1 Site Selection**

Data were collected at two sites: at Delmas 31, an inner city neighborhood in the capital, Port-au-Prince, and at Savanne, an urban settlement in Les Cayes, a provincial city located 112 miles to the south. Both sites are known as "bidonvilles," neighborhoods of extreme urban poverty with high population density, substandard housing, low literacy, and high unemployment. Political unrest following the September 1991 government crisis and delay in the implementation of the study made it necessary to eliminate a rural site which had been included in the original design.

In the site selection process, the principal investigator and research assistant made two visits to each location to discuss the project with local leaders, ascertain their interest, and explore criteria for selecting focus group participants. Several factors were taken into account in the process of choosing the sites. First, to ensure local support for the project, it was important to identify areas with local leaders who would be sympathetic to the goals of the study. A second task was finding a network of contacts that could provide access to individuals in the community who would form the focus groups. Third, the site had to have accessible meeting places with sufficient privacy and quiet to permit taping focus group discussions. Finally, a critical selection factor was the question of safety, not only for the field team but for the local residents who would be invited to gather in focus groups. An uneasy political climate made it necessary to select a politically neutral environment in which the purpose of the focus group meetings would not be misinterpreted and residents would feel free to convene.

Meeting places that satisfied these criteria were associated with child care services. In the Delmas 31 quarter of Port-au-Prince, a health center connected to Grace Children's Hospital, a well-known and respected non-government medical facility, offered space on its premises after clinic hours. The Medical Director of the Hospital and the Director of Education, who was also a member of the Advisory Committee, recommended community health personnel who could serve as channels to the study population. In Savanne, focus group meetings were held in the day care center of La Maison des Enfants de Bon Dieu (*Cay Timoun*), a Catholic mission that served the mothers and children of the community. The Sister in charge of the day care program expressed grave concern about the recent spread of AIDS in the area and offered to support the study by providing space in the Center. An equally critical source of support for the Savanne study was the Committee for Women and AIDS (*Comité des Femmes contre le SIDA*), composed of local women representing diverse networks in Les Cayes. This committee is an exceptional example of grassroots organization against AIDS. At the time of the study, a small but growing number of women in Les Cayes had been working through their own informal contacts and without external support to promote AIDS prevention and provide counseling to afflicted families. A member of the committee was the principal link to the study population.

### **1.4.2 The Field Team**

Working in teams of two, six trained moderators completed a total of nine focus group sessions at each research site. Local facilitators at each site helped with recruitment of participants and meeting arrangements. Training and on-site supervision were the responsibility of the principal investigator and her research assistant.

### **Selection and Training of Moderators**

Prior to the selection of moderators for this study, sixteen men and women were assembled for a four-day training seminar in the method and techniques of qualitative data collection in focus groups. The seminar was sponsored by the Child Health Institute in collaboration with Technique d'Administration, d'Animation, et de Gestion (TAG) of Port-au-Prince. Training included simulated practice with role-play in conducting small group discussions on topics related to sexuality and AIDS. On the basis of their superior performance in the seminar, four women and two men were selected to serve as the field team of the present study. This group received additional training from the principal investigator and the research assistant, including supervised field practice using a preliminary draft of the focus group guidelines on a population similar to that of the study. The moderators also participated in pilot tests of the final version of the guide.

Although none of the moderators had previous experience in the focus group method, four were experienced interviewers who had participated in surveys. Two who did not have interviewing experience were students in psychology at the University of Haiti. During the practical training, all six demonstrated aptitude and beginning skill in the use of the focus group guide to manage discussions on sensitive issues.

### **Facilitators**

**Selection.** Three facilitators – two women and a man – were nominated by a community leader at each research site to assist with data collection. Criteria for selection emphasized knowledge of the community, the trust and respect of peers, interpersonal skill, ability to understand the requirements of the project, and ability to read and write simple Creole. In Port-au-Prince, a public health nurse recommended three health agents. In Les Cayes, a member of the Women and AIDS Committee, who was also an auxiliary nurse in the study community, identified three local residents who met the criteria.

**Role.** The role of the facilitators was to help orient the research team to the community, to identify candidates for focus group participation according to specified criteria, to complete the demographic data form, and to assist the moderators with such practical matters as welcoming participants to the site, guarding privacy during the session, and serving refreshments provided by the research team. Facilitators were not present during the focus group discussions.

**Training.** Facilitator training consisted of discussion of the following:

1. the project, including its rationale and goals and a basic explanation of the focus group method.

2. the role of each member of the field team.
3. criteria for selecting candidates for participation.
4. a protocol for inviting candidates to come to the group meetings.
5. the demographic data sheet which the facilitator would complete for each candidate who agreed to participate in the study.

Handouts written in Creole reinforced points discussed in the training sessions.

### **1.4.3 Data Collection**

#### **Focus Group Procedure**

Each pair of moderators conducted one discussion with each of three focus groups at the two sites, a total of 18 sessions, 12 female and 6 male. Men and women moderators worked with same-gender groups, which ranged in number from 7 to 11 participants (mean = 9.4).<sup>1</sup> Although both moderators were free to contribute to the group process, one was responsible primarily for guiding the discussion and the other for taking notes to be used later in transcribing the data tapes. Each session began with an introduction in which the discussion leader and note-taker introduced themselves, summarized the general purpose of the meetings as a concern for family health, and explained how the discussion would be conducted and recorded, noting the presence of a small tape recorder.

In explaining the purpose of the session as an opportunity to learn how people feel about certain topics of family health, the moderators also stressed that they themselves were not health experts and that they had not come to provide information or education. They encouraged free expression on the issues to be discussed and assured the participants of anonymity. Each participant was asked to wear a number which enabled researchers later to link demographic characteristics with dialogue on the transcript. Focus group discussions lasted 1/2 to 2 hours, followed by sandwiches and soft drinks. At the conclusion of the meeting, participants received small gifts to acknowledge their contribution to the study.

#### **Focus Group Design and Composition of Groups**

To ascertain the views of different subsets of the study population, participants were assigned to groups on the basis of four variable characteristics which might be associated with perspectives on HIV risk and behavior change. These were gender, residence, employment, and marital status. Socioeconomic status was held constant in the selection process. Due to the concentration of poverty in bidonville communities, recruitment in these areas targeted exclusively the most economically disadvantaged members of Haitian society.

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<sup>1</sup> The moderators also conducted a series of key informant interviews. These are not included in the present report.

Ages ranged from 20 to 40 in the women's groups and 25 to 45 in the men's groups. No attempt was made to group participants according to age, since preliminary observation in the field had revealed no serious constraints on discussion between younger women and older women, nor between younger and older men. The important age criterion was the perception that other participants were sexually active adults, in contrast to "children," who were not yet expected to have informed opinions on sexual matters. In the case of younger women, having borne a child appeared to be a more important criterion of adulthood than chronological age. Local members of the field team were instructed to exclude women under 25 who were not mothers as well as men and women who to the best knowledge were not currently engaged in any type of sexual union.

For purposes of comparison, the following categories were established:

**Region.** Research sites were selected in two regions with different degrees of exposure to the AIDS epidemic and to mass information about the disease and its prevention. Delmas 31, the neighborhood selected for the Port-au-Prince data, is one of the more economically disadvantaged zones of the city. AIDS awareness messages are broadcast frequently on radio and television, and many health centers have incorporated AIDS prevention in their primary health care services. Until the shut-down of many factories shortly before the study, worksite AIDS prevention programs were becoming increasingly common in Port-au-Prince. On the other hand, HIV infection has appeared more recently in Les Cayes, where Savanne is located. While AIDS prevention messages can be heard occasionally on the local radio network in Les Cayes, intervention programs were believed by local health officials to have reached fewer people in the general population than they had in Port-au-Prince.

**Gender.** To encourage free expression on sexual issues, men and women were assigned to different groups. This homogeneity of gender enabled the investigators to examine potentially contrasting views and experiences concerning AIDS risk behavior and sexual negotiation.

**Employment.** In contrast to males, few lower class women in Haiti have ever been wage earners. At the time of the study, most factories had closed and unemployment in the bidonvilles of Port-au-Prince and Les Cayes was close to 100 percent. Prior to September 1992, however, many women were employed in low-level assembly jobs in Port-au-Prince factories. Some of these factories had started AIDS prevention programs, including a peer education program developed by the Group pour la Lutte Anti-SIDA (GLAS). Although for this study it was not feasible to identify individuals with direct exposure to worksite AIDS prevention programs, assignment of Delmas women to focus groups was controlled for past or present employment in order to examine possible differences in the association between factory experience and women's knowledge of AIDS and their perspectives on sexual behavior.

**Marital Status.** To examine the extent to which the stability of women's sexual relationships might be associated with their views on sexual decision-making, an attempt was made to identify marital status. In Savanne, assignment to focus groups divided women between those known to be in relatively stable unions (*maryaj, plasaj*) and those in less stable relationships (*vivavek, rinmin, ménaj, tizammi*). Placement was determined by the local facilitators' knowledge of the women's marital and household status. The complexity and instability of conjugal relations in Haiti made this variable a very difficult one to control. Facilitators in Delmas, in fact, felt that the task of assigning people to groups by marital status would be too difficult to undertake. Therefore, this category was established only in Savanne.

At both sites, however, "type of union" was included in the demographic information facilitators collected from individual participants before the focus group meetings.

### Composition of the Groups

Delmas:	2 groups of women, aged 20-40, employed or formerly employed in local factories
	4 groups of women, aged 20-40, no factory employment
	3 groups of men, aged 25-45
Savanne:	3 groups of women, aged 20-40, currently living in unions defined as <i>maryé</i> or <i>plasé</i>
	3 groups of women, aged 20-40, in <i>vivavek</i> , <i>ménaj</i> , <i>rinmin</i> , <i>tizammi</i> , or other non-stable unions
	3 groups of men, aged 25-45
Total:	18 focus group sessions

Focus group design studies frequently limit participation to unacquainted individuals on the assumption that people are able to express their views more freely in the presence of strangers. In the experience of Haitian community development workers, however, the opposite is true. Because disadvantaged Haitians sometimes distrust strangers, they are reluctant to speak openly in an unfamiliar gathering. Moreover, in homogeneous communities such as the bidonvilles of this study, it is difficult, if not impossible, to identify sets of individuals who are unknown to each other. Facilitators were therefore instructed to invite people in the community to participate regardless of whether or not they were already acquainted.

Focus group participant characteristics are summarized in Section 2.1 and in Appendix A.

### Research Instruments

**Focus Group Guide.** A set of open-ended questions in Creole served as a guide for moderators, directing the discussion on AIDS awareness and issues in decision-making, empowerment, and communication. The guide used in women's groups was also used for men with slight modification. Principal topics contained in the guidelines were household decision-making; sexual decision-making and women's rights; AIDS: transmission, susceptibility, and seriousness; consequences of AIDS for the family; talking with a partner about sexual risk; strategies to lower personal risk; discussing AIDS with other women (women only); and discussing AIDS with children. The format consisted of open-ended questions with probes for clarification and specific reminders to prompt the moderators on what to look for. The relative inexperience of the moderators made it advisable to provide more structure than is usually

required in a focus group instrument. Nevertheless, moderators were instructed to exercise flexibility in the wording of questions, to probe and explore, and to improvise as needed to encourage open discussion.

Advisors had cautioned that women in the target populations might be reluctant to discuss sexuality and unlikely to give reliable information on sexual behavior. The issues to be explored were therefore embedded in a vignette in which a hypothetical character, a woman named Joujou, is portrayed in a subordinate relationship with a man, René, whose sexual behavior puts her at risk of HIV infection. The purpose of this adaptation was to relieve the pressure of self-disclosure by asking the women to comment on the decisions and problems of another person. Since in pre-tests men and women responded equally well to this technique, the same story was used for both female and male groups.

In the story, "Joujou" has several children, is economically dependent, and must defer to René for decisions concerning the use of family planning, the food she cooks, and whether to take a sick child to the clinic. When she discovers that René has other sexual partners, she fears that he will infect her with HIV and must decide what to do. Focus group participants were asked to comment on the situation and to suggest a course of action for Joujou. Using neutral terms like *fi* (young woman) and *neg* (guy) instead of "wife" and "husband," moderators asked participants to explain their responses in terms of decisions or behaviors they would expect from people like themselves. Thus for the most part, comments were interpreted as participants' perception of cultural norms, rather than as statements of their own behavior. (See Appendix B for an English translation of the Guide.)

A pilot test of the guide was conducted in focus group discussions with four groups of women and two groups of men in neighborhoods of Port-au-Prince which were socio-demographically similar to the study sites. Moderators from the field team led the discussions and participated with the investigators and members of the Advisory Committee in the analysis of the results and subsequent modifications of the instrument. Modifications were made to clarify wording and enhance the cultural relevance of the language used in the guide.

**Demographic Data Questionnaire.** On-site facilitators used a simple structured questionnaire in Creole to record basic socio-demographic information on focus group participants. The questionnaire included the following variables: age, marital status, number and age range of children, formal education, literacy, source and amount of income, religious affiliation, and use of a family planning method.

## **1.5 Data Analysis**

The focus group data consisted of Creole transcripts from 18 recorded sessions. These were translated into English by professional Haitian translators. To establish accuracy, sections of the translations were drawn at random for independent re-translation and verification by the Haitian co-investigator.

A computer-assisted text analysis was carried out with the use of *Orbis*, a program of *Nota Bene*. This software package contains tools for searching and retrieving text from a large qualitative database, in this case the verbatim transcripts of approximately 27 hours of focus group discussion. By entering codes to designate relevant themes and sub-themes in the transcripts, the researchers were able to extract and assemble in one document portions of the

text which pertain to specific study objectives and which otherwise were scattered throughout the transcripts as they occurred naturally in the course of many taped discussions.

The demographic data collected by local facilitators at each site were used in this report to identify salient characteristics of individual speakers in the focus group discussions.

### **1.6 Validity of the Data**

Results of the pilot test and the use of the focus group guide in the actual research indicated a high level of face validity. Discussion topics were relevant to actual concerns of participants, as demonstrated by the intensity with which they debated the issues. The story-telling adaptation enabled participants to express opinions without disclosing personal behavior, and moderators reported that for the most part they spoke openly on sensitive issues, without evidence of embarrassment. The strong tendency on the part of both women and men to identify with the story characters and to speak from personal experience and conviction offset to some extent problems usually associated with hypothetical questions. The consistency of responses on certain topics among groups of similar characteristics and between the women and the men offers additional evidence of the validity and reliability of the results. Men and women frequently voiced analogous concerns, particularly with respect to norms of behavior that relate to women's risk of acquiring HIV.

Although every effort was made to encourage individuals to express honestly their opinions and observations, one important caveat remains. Discussion in this study was particularly susceptible to the effects of group interaction. As a new and frightening phenomenon, AIDS is a topic charged with emotion ranging from suspicion and doubt to fear and anger. Therefore, the knowledge and opinions of more outspoken members could well have had an influence on the views expressed by others. The tendency of a group to move toward consensus is a normal outcome of interaction on controversial topics, however, and in that sense reflects a natural process.

## **II. PRESENTATION OF FINDINGS**

### **2.1 Introduction to the Findings**

This section draws from transcripts of focus group recordings to report findings on principal themes and sub-themes which emerged from the discussions. Highlighting areas of consensus and contradiction, we examine common beliefs, expectations, and assumptions behind much of the taken-for-granted behavior that is associated with the status of women in the sexual relationship and hence with the spread of AIDS. We also assess women's perceptions of their capacity to counsel others on protecting themselves from HIV.

In Section 2.1, we introduce the findings with a discussion of terminology and present characteristics of focus group participants by category. To gauge the participants' level of understanding of HIV, we summarize discussions of transmission from both the men's and the women's focus groups in Section 2.2 and comment on the similarity among groups. We then report findings from discussions among women participants concerning their perceptions of risk, their sense of personal vulnerability to the disease, and what they believe are the

consequences of AIDS for families (Section 2.3). In Section 2.4, we report findings on prevention, including women participants' knowledge of, and concerns about, self-protection, as well as their views on the rights of women to intervene in sexual behavior that increases their risk of contracting HIV. The discussion highlights women's attitudes toward male sexual freedom and condom use in relation to female participants' perceptions of women's capacity to initiate behavior change. Section 2.5 then turns to men's perceptions of women's rights in the sexual relationship. This section reports comments from men's focus groups concerning traditional male expectations of female behavior and indications of a possible shift in attitudes as the AIDS epidemic advances. We focus particularly on men's views on how women can avoid contracting HIV, including strategies they think women should use to avoid sex with a promiscuous partner or to initiate the use of condoms, and how male participants believe men may react in such situations.

Section 2.6 deals with the way women see their role as advisors on AIDS prevention to two groups whom they might be in a position to influence: adolescent children and other women in their families and communities. It also includes women's views on the special vulnerability of young people and the range of responses they would expect their intervention to elicit from adolescents and their female peers.

Section 2.7 summarizes and discusses the findings presented in this report in relation to the study objectives outlined in Section 1.2.

**A note on terminology:** The investigators have attempted to distinguish focus group participants' views on women in relatively stable relationships (*maryaj*, *plasaj*) from their opinions on people in less stable sexual unions (*vivavek*, *rinmin*, *tizammi*, *ménaj*). Moderators were instructed to use neutral terms such as *neg* (guy), *fi* (girl or young woman), and *patné* to mean partner, whether temporary or well established. However, the participants, themselves consistently used the terms *mari* (husband) and *fanm* (wife), which made it appear that, for the most part, they were interpreting questions in the context of a stable relationship. The terms, husband and wife, did not occur in the story of Joujou and René, and the children were attributed only to Joujou, but the fact that they all lived under the same roof apparently led most respondents to define the couple as *maryé* or *plasé* and to assume that the children were René's responsibility. By interpreting the story and the moderators' questions in these terms, participants structured the problem according to cultural definitions of gender relationships.

As used by focus group participants, the terms husband and wife generally applied to any union in which a man and a woman are living together under customary rules that define a conjugal relationship. Participants usually referred to a wife as a woman who lives with a man, keeps house for him, provides sexual gratification, and bears his children. The terms *fanm*, or *madanm*, implied that, in exchange for material and emotional support, the wife, or woman at home, would not only carry out her domestic duties but would give up any sexual relationships she might formerly have had and remain faithful to the husband, or man who supported her. However, participants occasionally used these terms in the plural, distinguishing between the wife at home and other *wives* elsewhere. Since some men maintain more than one household, the plural reference to *wives* probably indicates long-term unions with more than one woman simultaneously, in contrast to more casual, transient, and uncommitted relationships.

While women would prefer that their steady partners also turn their backs on other women, fidelity seemed to be a luxury that few could expect. That is not to say that women in stable

relationships never have outside men, themselves. Focus group participants of both genders acknowledged that *wives* as well as *husbands* may have "outside" partners who are responsible for the transmission of AIDS first to the women and ultimately to their husbands, or primary partners, as well. This report uses the term primary partner interchangeably with the terms husband and wife to include married (*marye*) as well as common-law (*plase*) relationships, two terms which are also used interchangeably. Although the taxonomy of sexual relationships in Haiti is differentiated by several types of union mentioned above, the authors use the term *vivavek* as a generic adjective for unions which are relatively less stable and less binding than marriage, whether legal or common-law.

It is also worth noting that, while moderators asked their questions in the third person, participants often responded in the first or second person. To encourage free expression, the focus group guide phrased most questions in general terms that could be interpreted by participants as invitations to express an opinion or to share the experience of people *like* themselves. In much of the discussion, however, participants shifted the perspective away from the generalized other and toward a more personal syntax in which they obviously identified themselves (I/we) or their peers in the group (you) with the issues under discussion.

Segments of dialogue from the translated focus group transcriptions are reproduced throughout Section 2 to illustrate the way participants expressed their views on issues related to the study objectives. An identity code composed of the letter P and a number identify each speaker in the group. Comments which could not be so identified are designated PX.

## Participant Characteristics

Appendix A contains a summary of focus group participant characteristics across the six categories as collected by local facilitators prior to the discussion sessions. There was little variation in mean age (29 years to 31 years) and a similar range in each category from 20 to 40 years (women) and 25 to 45 years (men). Savanne women in stable relationships tended to have more children (mean = 3.9) than Delmas women, and *vivavek* women and men in Savanne had the fewest (means = 1.9, 1.7).

Socioeconomic data confirmed the initial assumption that participants in this study would have little education and very low income levels. Income was consistently low, ranging from 54 percent of men in Savanne to 100 percent of non-factory women in Delmas reporting no stable income. This finding is not unexpected in view of the political and economic crisis a few months earlier which had resulted in the closing of many factories and workplaces. Among participants who reported income, the majority earned less than H\$3 per day.

The chief difference between participants of Savanne and Delmas was in women's education levels. *Vivavek* and stable women in Savanne were particularly disadvantaged in this respect, with less than 25 percent literacy and school attendance. In contrast, sixty-seven percent of Delmas women factory workers and 76 percent of other Delmas women had attended at least primary school; 70 percent and 76 percent respectively said they were able to read and write. Men at both sites were more likely to have had formal schooling (Savanne 80 percent, Delmas 90 percent) and to be literate (Savanne 73 percent, Delmas 79 percent).

Among Delmas women, marital status proved to be a difficult item for the facilitators who completed the demographic data forms. Since recording errors invalidated this item for over half the female participants in Delmas, the distributions summarized in Appendix A do not

include Delmas women. Although the data for men in Savanne and Delmas and for the female categories in Savanne were intact, they deserve cautious interpretation. The lack of mutual commitment in many unions is associated with frequent change and multiple relationships that may not have been reported. In addition, participants may not always have been willing to admit to local facilitators that they lived in unstable unions, and facilitators may have been uncomfortable about revealing information which they believed would be viewed negatively by the research team.

The demographic summary reveals low contraceptive rates, especially in Savanne, where none of the *vivavek* women and none of the male participants reported current use of a contraceptive method. Men in Delmas had the highest reported current rate, 61 percent, but 41 percent of the Delmas women factory workers and 52 percent of other Delmas women said they had never used family planning.

## ***2.2 Causes of AIDS: Men's and Women's Knowledge of Transmission***

**If she has AIDS, the germ has to spread ...**

It is now common knowledge in Delmas and Savanne that AIDS is a sexually transmissible disease. In all the focus groups of this study, women and men were acutely aware of the risk posed by sexual contact with an infected person and offered strikingly consistent explanations of how unwary partners may become infected. The more partners one has, they explained, the greater is the risk of acquiring the disease and transmitting it to others. In a typical exchange of views on transmission, men in Delmas demonstrated their understanding of this process:

Whatever woman you have sex with, if she has AIDS the germ has to spread to other people, because you get it from the first one, the second one, the third one – and none of those women has sex only with you. They spread the disease among (all their) young men.

*Moderator.* Do you think the man will infect his wife at home?

Yes, when the man has sex with another woman he does not know if she has AIDS or not. Then when he makes love with his wife, his wife is contaminated. He did not know.

I don't think you can get (AIDS) the same way you get tuberculosis or other diseases.

No, according to what I've heard, there is only one way you can get AIDS. You can get it if you make love, when you have intercourse with other women. I don't think you can get it if you just sleep with the person and you do not do anything with her.

Women's views on transmission were similar; both men and women constructed an explanation for the transmission of AIDS in a network of relationships. Men were usually described as the link between women on the outside infected with AIDS and women at home, either wives or relatively steady partners who were not expected to be involved in other sexual

relationships. The implication was that it is the "other women," not the "wife" at home, who are most responsible for the spread of AIDS. In effect, men were most often portrayed as vectors of disease, oblivious to the consequences of their sexual adventures. A 40-year-old married father of three in Delmas compared it to bringing home a tick:

It happens just like when a person walks in the bush and a small parasite drops on him. When that person arrives in his house, the parasite gets in the ear of a child and becomes a tick. This is how he can bring home the disease (AIDS). He gets it outside and brings it home.

From time to time participants acknowledged that the extra-marital affairs of women in stable relationships may also lead to HIV infection, but most of the discussions supported the notion that "wives," or women with domestic as well as sexual responsibilities, were less likely than their men to have liaisons outside the home. Multiple partnerships are treated in more detail in Sections 2.3 to 2.5.

### **It's from blood that you can catch it...**

Participants were aware of the role that infected blood plays in the transmission of AIDS, although their concerns were sometimes exaggerated. They worried most about injections that people receive in clinics and were concerned that nurses or doctors might use the same needle or syringe for infected and non-infected patients. A Delmas man told his group that when he visits a doctor, he feels he must look in the doctor's drawer to "find out if he is giving me an injection and if he is using the same syringe. I would rather go out and buy a syringe," this man said. Concern about exchange of blood also surfaced in other ways, varying from the plausible to the impossible. Participants seemed to have given considerable thought to the risk of transmission through casual relations which might involve contact with infected blood or other body fluids. For example, in all groups except the women factory workers in Delmas, there were references to transmission by kissing and the transfer of saliva. The risk associated with kissing was almost always linked to the presence of sores, cuts or dental cavities which they believed would allow passage of blood from the infected to the uninfected person. The same reasoning applied to the risk of touching an open lesion or washing an open wound in water used by an HIV-contaminated person. There were no dissenting voices to the assertion that blood is a channel of transmission, but on the issues of saliva and of casual contact that does not expose a person to blood, participants were not in agreement. Women in Delmas contributed various opinions on the issue:

*Moderator.* As far as you know, how does a person get AIDS?

If a man has sex with several women and the women have sex with several men, they will get AIDS.

You can get AIDS from syringes – also from blood-suckers. If the person who places the animal on you does not pull out the blood from another person who has AIDS, you surely

can get AIDS that way. Also, if you get syringes used by AIDS patients. The syringe should be new.

If you are sick and have a blood transfusion, the blood they give you is the blood of a person who has AIDS.

There is something that women don't know. They say that you can get AIDS through sexual contact only, but that is not true. You can get it through kisses, through the man's saliva.

To get it through kissing, the person would have to have a cut in his mouth. But it is not through the saliva – it's blood. People get AIDS through blood.

### **I think there are two types of AIDS ...**

Focus group moderators did not present the question of supernatural causation explicitly, but spontaneous discussion in three of the groups raised the possibility that AIDS transmission might result from malevolent forces. A never-employed non-literate woman in Delmas said she had heard that "a person with AIDS may curse someone else with it (*voyé li sou moun nan*) after his or her death. The doctor may think she has AIDS, but that is not the case. Then she can not transmit it to someone else." Comments from other members of her group neither supported nor denied the assertion. On the other hand, when the question of supernatural transmission arose in a group of female Delmas factory workers, there was both agreement and disagreement.

You can get the AIDS virus if a person who hates you throws the AIDS powder on you. (Reference to voodoo.)

I don't think so, because if it is only the powder they have thrown on my skin, I may see bad things, but the powder will not get into my blood.

It is only one wife-one husband (that prevents AIDS)

I don't think that if the person has died they can go and find him and make the AIDS powder with his body.

Men also spoke of "the AIDS powder," a reference to supernatural alchemy, and discussed the possible role of voodoo on AIDS transmission and diagnosis. A man in Savanne explained how a case of AIDS caused by a powder can be misdiagnosed in a laboratory with the result that the victim may neglect to seek appropriate treatment from a *houngan* (voodoo priest) and may subsequently die. His explanation and reasoning seemed to be accepted without further discussion by others in the group. However, when a man in another Savanne group implicated supernatural practices in the transmission of AIDS, other participants disputed his allegation. The issue, however, was not one of religious belief but rather of scientific logic pivoting on the question of whether HIV-infected blood can affect a person in a poisoned drink.

There's another way you can get AIDS. If a healer does not want you to live, he can get blood from a person who has AIDS, prepare a mixture with it, and give it to you to drink. I'm sure you can get AIDS that way.

I don't agree with that answer. You can get many diseases in water and food but not AIDS. You can get it because of wickedness but not in food and water. If people could get AIDS in food, all Haitians would have it, because all the food you eat is unclean.

### **You can get AIDS in water, in food, in humidity ...**

Transmission through casual contact was cited more often by men and women in Savanne and less often by the factory workers in Delmas. In all categories, however, there were people who believed that an AIDS-infected person would endanger other household members. They mentioned several modes of transmission, including drinking or washing in water contaminated by a person with AIDS, sharing food and eating utensils, sitting on a common chair, and using the same toilet. Sometimes they supplied detailed explanations of how the blood or body fluids of the infected person might come to be on the contaminated article. Participants in Savanne were most likely to mention mosquitoes and flies as vectors and to express concern about infected meat. One man in Savanne explained that AIDS, like anthrax, passes to consumers who unknowingly purchase meat from sick animals in the market.

My wife goes to the market and buys meat coming from that (infected) beef. If you eat the meat, you eat its blood also, because the blood gets into the meat, and you get anthrax. The same way also, the beef can have AIDS.

Another man in the same group blamed outdated milk, but others disagreed:

You can get AIDS in certain products that come from America. In the United States they tell you that milk can be used up to a certain year. When the date expires, they throw it away. Haitians who live abroad and want to set up a business may buy it and sell it to you.

I don't agree. You can get other diseases in food but not exactly AIDS.

I have almost the same opinion. Milk can give you diarrhea but not the same diarrhea as in AIDS. You get AIDS if a person who has AIDS uses a syringe and you use it too.

These segments illustrate a common source of confusion in the minds of people for whom water- and food-borne disease is a fact of daily life. Nevertheless, although many suspected food and water of carrying HIV disease, there were always others ready to provide more accurate information and debate the issue.

### The baby could get the germ...

Vertical transmission from an HIV-infected mother to the unborn infant was rarely mentioned spontaneously. Even when moderators asked probing questions concerning means of transmission, the danger of perinatal infection seldom came to participants' minds. When discussion turned to issues of vulnerability and the consequences of AIDS for the family, only then did a few people volunteer the information that unborn babies may be at risk. In response to a moderator's question, "What kind of person can get AIDS," a man in Savanne explained that "if the father has the virus and has sex with the mother, and if the mother gets pregnant, the virus gets inside with the germ" (sperm).

Women in Savanne reacted similarly to a question concerning their responsibility to protect an unborn child:

I have to protect myself so that I don't get AIDS, but as for the child, if the man already has the virus and transmits it to the child, the child will be born with it.

I can protect the child when I am pregnant if I am having sex with only one person. But if I am pregnant with my husband's child and I am fooling around with other men (*viv ak yon lot moun*), then the child may get it (AIDS) in the womb.

I agree with you, but even if I am involved with just one man, I must protect the child. I will get vaccinated, and when the child is born I will get her vaccinated to protect her, too. That is all I know.

It was not clear from the above dialogue whether the participants were attributing AIDS in the newborn to the behavior of the mother or the father – or both. However, a comment from a 22-year-old Savanne mother in a *vivavek* relationship may provide a clue to their reasoning:

When the child is in the womb and the woman or the baby's father has AIDS, the AIDS germ gets into the baby's blood. Since it's the same germ that makes the child, it can cause the child to be born with AIDS.

These comments reflect some confusion about the relationships between the sex cell, the AIDS virus, and other micro-organisms. All of these were referred to throughout the discussions as "germs" (*jem*).

The woman above who alluded to vaccination was the only participant in this study to associate immunization with AIDS prevention, but her comment stands as a warning that others may also gain a false sense of security from preventive health measures that have no bearing on HIV transmission.

Thus, people in all the study groups wrestled with the logic of many fragments of information, some scientifically valid, others partly true or distortions of actual fact, others with no scientific basis. Some participants expressed confusion or uncertainty in the face of so many conflicting notions. "The problem of AIDS is very hard to understand," said this woman factory worker in Delmas:

They say that male homosexuals transmit it. I have seen male homosexuals since I was a child, and I don't see them die. Sometimes they say that female prostitutes transmit the disease. Sometimes they say it is drugs, sometimes women and men with several partners. I think that nobody knows what causes AIDS. I think it is a God-given disease aimed at destroying human beings.

Women who worked, or had worked, in Port-au-Prince factories were least likely to suggest inaccurate modes of transmission. Differences were negligible among the other five categories, in all of which there were people who expressed exaggerated or inaccurate ideas about how AIDS can be transmitted. Nor were there discernible intragroup differences on the basis of schooling and literacy. One consistent theme left no doubt as to the dominant belief about the most important cause of AIDS: sexual contact between men and women, either of whom has had sex with more than one partner.

### ***2.3 Women's Beliefs about Vulnerability and the Consequences of AIDS***

Just as the majority of women in Delmas and Savanne were aware of the role of sex in the transmission of AIDS, most also believed strongly in the vulnerability of people like themselves and expressed fear of the consequences of the disease for their families. Others, like the Delmas woman above who felt overwhelmed by many bits of information, were confused. Another Delmas participant, a woman with no factory experience, believed that people differ in their susceptibility to the HIV virus.

Okay, I can eat and drink with a person who has AIDS and I will never get it (because) I am not susceptible (*mwèn pa nè pou sa*). Another person only has to touch him to contract it.

Although doubts lingered in the minds of a few, it was evident that for most women AIDS was not only a familiar illness, but one to be feared for reasons that emerged with consistency in all participant categories.

#### **The disease is worse than evil ...**

Women usually expressed their fear of AIDS in terms of inevitable death and the suffering it would cause the family. Many spoke of the economic costs when the breadwinner dies, the break-up of the family unit, poverty, destitution, ostracism, and even the spread of the disease to other family members. "The disease is worse than evil if it takes away a family member who used to help you financially," said a woman in Savanne with no income of her own. A Delmas street vendor and mother of three echoed her fear:

It destroys the family. If you have a person who was the head and AIDS gets to him, the whole family is destroyed. There is nobody to help us anymore. Those who were in apprenticeship can't go on, those going to school have to stop.

A 36-year-old woman factory worker may have been conscious of her own responsibilities when she said,

It (AIDS) has many consequences if you are the one helping out the family and taking care of a household. Mother, father, brothers – they all depend on you. Then the disease comes, and all that is left is death.

Participants focused particularly on the effect of AIDS on surviving children. Phrases such as "AIDS crushes families," "kids have no future," and "children in misery" were common. A Delmas woman with a husband and two children warned:

If a mother and father die of AIDS, the family is finished. All the children will suffer. They may become wanderers (*vagabon*), thieves, or drug-users, because they don't have parents.

A woman factory worker in a *vivavek* relationship expressed the same concern differently when she argued that a woman with children should not continue to live with a man who has other partners, because:

... the wife will die, leaving all the children. After she dies, each (child) will live apart somewhere, while the man will go and live with his other women.

Only one woman, a Delmas mother with secondary school education, spontaneously mentioned perinatal transmission as a consequence of AIDS for the family.

### **This disease gives the family a bad reputation ...**

Although not a major theme, the possibility of social rejection as a consequence of AIDS arose several times. In all categories except the married (*maryé/plasé*) women of Savanne, participants alluded to the stigma suffered by a person with AIDS. A Delmas factory worker said she feared AIDS because of what people would say afterward to her children. "I wouldn't like to die strangely and have my children go through misery later when people ostracize them and tell them that their mother died of AIDS." One group of *vivavek* women in Savanne was also concerned about the family's reputation in the community when a member develops AIDS. "If someone in your family has it and another person speaks to you," said a woman in this group, "he curses you." Yet, despite their concern for the family image, women rarely suggested that AIDS-infected members would not be received and cared for in their homes.

For the most part, women across all groups had a realistic fear of the consequences of AIDS. It was not clear whether their failure to focus on risk to the unborn child represented acceptance of child mortality as a fact of life or a gap in their knowledge of HIV transmission, but other data indicated the latter. Their preoccupation with economic loss and social consequences for abandoned children exceeded by far their concern about having to care for the sick, a reminder perhaps of many women's dependency on others for survival. Women tended to hold similar views on the risks and consequences of AIDS, regardless of differences in characteristics such as age, education, marital status, and employment.

### **You can recognize them ...**

When asked how one recognizes a person with AIDS, some women listed such classic signs as weight loss, diarrhea, fever, and sores, as well as more exaggerated and inaccurate criteria. Others countered that a diagnosis of AIDS must be confirmed by laboratory test or medical opinion, but some doubted the physician's willingness to tell the patient the test results. Comments like the following from a segment of the discussion in Savanne are typical of women's responses on this topic.

If a person has it, everyone will notice after two or three days, because your hair thins out and becomes silky, your belly may become bigger, and you may have bumps all over your body.

You have bumps, diarrhea, cholera, and poliomyelitis; after a couple of days, you die.

Only the doctor can tell you if the person has AIDS.

You should go to the doctor for an examination. Some doctors may find out that you have it but not tell you. The doctor may think the patient will die before his time if he knows he has (AIDS).

Some people don't even want to eat when they know they have AIDS. They live in constant fear.

If the person has diarrhea, the type that doesn't stop in spite of all the medicine he has taken. Once a woman came back from Port-au-Prince with diarrhea that couldn't stop. She had a baby and they didn't even want her to breastfeed it. This diarrhea was the cause of her death.

### **My husband is not fooling around out there ...**

Although women concurred strongly that "anyone can get AIDS," in each category there were some who felt they were exceptions to this rule. Many qualified their remarks with statements that people do not need to be afraid if they do not "fool around" (*viv deyo*), referring to the practice of sexual encounters outside the regular partnership. Remarks such as "If a woman has confidence in herself (*fe respe*) and the husband she is living with, she knows she will not contract the disease" and "if they can trust themselves, they will have no problem" illustrate their cautious optimism. The discussion often turned to personal testimony, with assertions of their own responsible behavior and sometimes also the fidelity of a husband or regular partner, but there was less conviction about the latter. Others based their confidence on religious belief. One such woman, a Protestant from Delmas, feared AIDS from hospital treatment but not sexual transmission:

I am afraid because if I am sick and go to the hospital, the doctors might say that I should have a blood transfusion, and blood can be contaminated with the AIDS virus. Other than

that, I am not afraid, because my husband is a Christian. The true Christian has one wife, and his wife has one husband. They don't fool around.

Another Delmas woman also defended herself but with an edge of uncertainty about her husband's behavior. She explained at length that her decision to use condoms for family planning had nothing to do with fear of AIDS, since "he doesn't see (*viv ave*) other women." As for herself, she assured the group that she "does not fool around (*mwen fe respe mwen*). God will not let me contract AIDS unless I go around looking for it." Then, as if to allay an edge of doubt, she added, " Even if my husband is promiscuous, I would know if he were coming to give it (AIDS) to me. God will see to it that he does not transmit it to me."

### **We are afraid ...**

Few women shared even the guarded confidence of some of the Delmas participants quoted above. In every category they spoke of the unpredictability of AIDS transmission with respect to several recurrent sub-themes: You can't tell who has it; you can't trust your partners; some people give AIDS to others on purpose; men won't listen; and, finally, if you refuse your partner, you only increase your risk, because he will find what he wants on the streets.

Not surprisingly, the Savanne women in *vivavek* relationships added another dimension to the problem: dependency on men for economic support. Women in more stable relationships face the same problem, but the *vivavek* groups were the most outspoken in their expression of dependency and personal vulnerability. When asked directly, almost all admitted to being very afraid, as in the following dialogue:

*Moderator.* I'd like you to tell me if women like you can get AIDS.

(All)           Everybody can.

Yes, everyone. There are no exceptions.

*Moderator.* Then are you scared, yourselves?

No – I'm not out there fooling around.

Not scared? Are you kidding? I am scared because life is short.

I am scared. I have two children who have no fathers. I am the mother and after God I am the father, too. I am used up from struggling to raise my children.

I am so scared of catching AIDS and having to be all by myself.

But if you stay by yourself, you are more likely to catch it, because you can't live like that. You can't pay for your house if a man doesn't give you money. You can't not catch it.

*Moderator.* Many of you are telling me you are scared. Why are you scared?

Because we are sleeping with men.

We are living with men who fool around a lot (*gason bouzen*).

A *vivavek* woman with five children and no steady income summarized the fears of other vulnerable women when she observed:

You have less chance of catching the disease (AIDS) if someone is taking care of you and feeding your children. If you are poor and trying to survive by living in the streets, you have no protection. It can happen to you more easily.

**You never know who has it ...**

When asked if it is possible to recognize an infected person, women in all categories were quick to compare what they had seen or heard about the appearance of AIDS in its later stages. These sometimes vivid descriptions were accompanied by warnings to avoid sexual contact with such individuals. When prompted, however, most acknowledged the possibility that infected people who do not appear ill may also transmit the disease. Women readily volunteered such comments as, "When they first catch it they don't look like they are sick" and "The AIDS germ doesn't appear on you easily – you're eating, you're looking great, and you have the germ." "I consider it like a lottery," said a married woman from Delmas. "If you're lucky you won't get it, but if you have bad luck you will."

The transcript does not reveal the kind of luck this woman believed might protect her from AIDS, but numerous comments from other women across all categories suggest that this kind of fatalism may reflect their painful awareness that one can never be sure of the HIV status of a sexual partner. The following segment from a *vivavek* group in Savanne illustrates the thinking of women in unstable relationships:

*Moderator.* What types of people have AIDS?

People who fool around.

People who, for example, have no husbands and are living with anybody. You don't know when the person has the disease. You might see that he's big and handsome, but his woman has the disease and you don't know it.

You might not have a husband, and you're picking up a couple of gourdes on the streets. You see a handsome person. You don't know who he is, and it's AIDS you end up buying.

Married women in Savanne had similar misgivings. "There are men," one warned, "who deny they are seeing other women (*nan fi deyo*). When they contract the (AIDS) virus, you will not

know they have it. It is only when they start having diarrhea that you know, and by then it is too late." Another woman in her group explained that "when the disease first penetrates the man's system, he may not know he has it. You as his wife won't know – you will contract it no matter what, because it doesn't appear full blown at first (*li pa vin ak fos*). You will always get the disease, because neither person knows." Similarly, a married woman in Delmas lamented, "Anyone can get AIDS. Even if we know everything we should do (to prevent it) we can get it. You never know who has AIDS." "I may be sleeping with (*mwen gen*) two, three, or four men," said a single woman in Delmas, "and I don't know which among them has AIDS. I will catch it and transmit it to my 'husband'."

### **The man goes out and his wife gets AIDS ...**

Driven by the realization that often they do not know with whom their partners are having sex, women were more vocal than men when it came to expressing fear. Not only is it impossible always to know who has AIDS, many women never know for certain whether their husbands or regular partners are visiting and contracting the disease from other women. A former woman factory worker, a married mother of three from Delmas, warned that René would probably "try to prove to Joujou that he is not involved with other women when he really is. With bad luck the woman he is seeing may have AIDS." Individually, many women volunteered that their own husbands were faithful to them, but the underlying consensus seemed to be that monogamous unions are rare. Women in all categories commented frequently that, married or not, men leave the house to have affairs with other women who may be infected. As a married Delmas woman put it, "The wife at home knows she is sleeping only with her husband and trusts him – so she gets AIDS." This comment prompted another woman in the group to add, "The man may be seeing another woman who is leading another life that she knows nothing about."

Women often personalized the issue of trust, stating that they, themselves, did not engage in extra-marital affairs but that they had misgivings about their men, as in the following comments of women in Savanne:

*Moderator.* What kind of people can contract the AIDS disease?

People who are fooling around (*viv deyo*), living promiscuously (*nan epav*), but if both people are not living like that, you will not get it.

What she says is right, (but) some women who live with men are not involved with other men (*li pa nan anyen*), while their men may be involved in everything (*nan tout afel*).

As I said, I am young and my husband is young. I have found condoms in his pockets when I was washing clothes, but he never uses condoms when he is with me.

I can't say that I won't get the disease (AIDS), because the man I am with (*m rete avel la*) lives in Miragoane, where there are a lot of Hispanic women (Dominican prostitutes). When he comes back, I don't get close to him (*m pa kole prel*), because he is a young man and the disease is concentrated in these women.

I am so afraid ... The man I am with (*m avel la*), he is always looking around (*pati koul agoch a dwat*). If I get it (AIDS) it will be from him. He may have seen a woman who looks very healthy (*byen gra*) so he goes and talks with her, sleeps with her (*rete avel*), contracts the disease, and gives it to me. The person may look healthy, but if she is a prostitute she has the disease.

"We are afraid," said a married woman in Delmas, "because even if you want to live (monogamously) with men, they do not want to stay with one woman." Another married Delmas woman volunteered that, "for myself, I would not be afraid, but the person I am with is not seeing just me, so I will always have fears." Later the same woman added:

As long as my husband is fooling around out there (*li tan ti pa chat deyo*) there's no telling when I will get the disease. It is a great burden not knowing what is in a person's heart (*sak nan ke moun nan*). You know your own heart, but with this disease, if you have a husband you don't know when you will or will not contract it."

And a Delmas mother of five in a *vivavek* relationship said,

You have to refuse sometimes, especially when the person is living like a tramp (*vagabon*), having affairs with other women. Sometimes they say you are responsible if they have affairs with other women because you don't want to have sex with them, but it's because you are afraid. You never trust men.

The uncertainty that these and other women were expressing is an important element in their fear of AIDS. They have heard and taken seriously the public health messages warning of the dire consequences of promiscuous sex, but they lacked a clear sense of personal empowerment to act on their own behalf.

#### **If I had AIDS I would not die alone ...**

The question of intentional transmission arose often enough to suggest that it is a concern that may add to the Haitian woman's sense of vulnerability to AIDS. A married woman in Savanne told a story in which a man gave a woman a large sum of money for sex, then "told her to eat well and wait for death." This participant was illustrating a point that others also made: people with money are to be feared, because they not only are more likely to have AIDS, but they can afford to disseminate it more widely to women they encounter on the street. A married (*plase*) street vendor in the group supported this view when she commented that a man "may know that he is going to die and yet offer you as much as \$200; if you like money, you may get AIDS." Why do some women feel a person would wish to infect others? The problem may be one more of disregard than of intention, but some of the women in Delmas saw it otherwise:

*Moderator.* Could a person who is infected but not look sick infect others?

When he finds out that he is going to die, he has sex with any person who comes to him. He has no pity. He is going to die, so he tries to kill other people.

If I had AIDS I would not die alone.

Since I got it from another person, I will give it to someone.

I would look for others and contaminate them.

Women in both the *vivavek* groups also raised the issue of deliberate transmission. "When a person finds out that he has the disease (AIDS), he is happy to give it to the other person so the other can have it, too," said one. When the moderator asked the other *vivavek* group to comment on whether a healthy appearing person infected with AIDS can pass the virus on to others, the answer was definitely yes. One of these unmarried participants, a 25-year-old mother of four, elaborated on the overall affirmative response of the group as follows:

Yes, he can give the germ that's inside him out of spite. The man knows he has it and makes all kinds of effort to give the woman the disease. If it's a woman, she might call a man and give it to him.

In Delmas, a woman factory worker gave her opinion that some men have no interest in AIDS prevention, because "they want to transmit it to you; they're malicious." Her negative views were echoed by another factory worker who advised others in her group to "beat" a man if he tries to infect her. Remarks such as these reveal undercurrents of anger, blame, and retribution with important implications for behavioral intervention that need to be explored.

## **2.4 AIDS Prevention Strategies and Women's Rights**

**If the woman stays only with her husband ...**

Focus group discussions confirmed the findings of previous studies that, whether or not they make use of the information, most Haitians know how to prevent HIV transmission. With very few exceptions, women concurred that the only way to protect oneself is to observe "one man – one woman" (*yon sel fi – yon sel gason*) or to use condoms. Nevertheless, the transcripts also revealed the gulf between what women know about prevention and what they believe they can realistically do to influence behavior that men have always controlled. When prevention was introduced as a topic for discussion, participants in each group recited as if in unison the rules of safe sex as presented in posters, in the mass media, at health centers and workplaces. Through skillful probing, focus group moderators peeled back the veneer of superficial knowledge, revealing deep-seated contradictions and conflicts between old norms of behavior and new prescriptions for change.

## Multiple Partners

The man is always out ... he does what pleases him ...

Focus group transcripts confirmed the observation that monogamous marriages are the exception rather than the rule for the majority of disadvantaged Haitians and that men, particularly, do not confine themselves to one stable partner. Women focus group participants were well aware of the tendency of men to have "outside women" (*fi deyo*) in addition to a woman at home (*fanm fiks*). The perception they shared of men's promiscuous sexual behavior was the backdrop against which they debated the many issues of sexuality and AIDS prevention that formed the substance of the discussions. However, "knowing" the habits of men in general did not necessarily mean that women have such information about the men they lived with. While a few volunteered that their husbands or steady partners had other relationships and others emphatically denied any such possibility, it was apparent that many simply did not know.

Participants made it clear that they would prefer monogamous partnerships but repeated references to the sexual freedom men enjoyed uncovered a sense of powerlessness to influence their partners' behavior. Women took the hypothetical Joujou's plight very seriously, defining it as a situation that demanded decisive action on her part. Since Joujou and René lived in the same house, René had the status of "husband," with an obligation to protect Joujou from AIDS, but the women usually did not agree on the best strategy for convincing him to accept this responsibility. Nor was there much expectation that René could ever be convinced to adopt a different sexual lifestyle.

Sexual freedom was a recurrent theme in every group, a privilege that men enjoy at women's expense. In a typical exchange on this issue, married women in Savanne spoke resentfully about the ability of men to make their own decisions about leisure time and money:

Life is easier for the man, because the woman has to stay home and take care of the children. The man has more free time.

The man is always out. He does what pleases him.

He may be giving money to other women while his woman and children go hungry.

Some men are sly as cats ...

As discussed in Section 2.2 in relation to women's sense of vulnerability to AIDS, they uniformly did not trust men when it came to sexual relationships. Many women commented that men believe they are in command, "the chief of the woman" with little or no accountability for his sexual behavior outside the home. A Delmas woman complained that a married man feels no obligation to tell his wife about children he has with other women. The pain of uncertainty came through the discussions in many different ways. A married woman in Savanne said resignedly,

When you think your man is 'fooling around' it hurts you, because you don't know how he's getting along with the other woman, and you can't help being jealous. Any new relationship has a sweeter taste, so it's easy for him to get AIDS and bring it to me.

"Some men are sly as cats," said another married Savanne woman. "Even if they do have other women, you'll never know until the other woman starts showing off and ridiculing you." Several women spoke of discovering their husbands' infidelity when they found condoms in their pockets. These and similar comments reflected the humiliation women feel when others know their partners are having affairs before they do. At the same time, women observed that to avoid "problems" between them, it is better for a man to think that his woman at home does not know. Several indicated that they would play that game in the interest of family harmony. One of the many ironies for Haitian women is that they are not supposed to know what their men do outside the house, but not knowing may open them to ridicule and eventually to unprotected sex with an HIV-infected partner.

#### **He would never throw away the old pot for a new one ...**

What can a woman do when she suspects her man of having other partners? Refusing sex was one alternative, but attempts to reason with the man, to cajole him into giving up the other women, seemed a better solution to some. A Delmas participant said, "A woman can talk to a man, and if he is a person who listens he agrees and gives up what he used to do." Women who spoke in support of this strategy hoped that by explaining the danger of AIDS transmission to a man, his wife or regular partner could appeal to his sense of duty to protect her life and the welfare of his family. Some said that words were not enough, that it is the woman's responsibility to satisfy her man so that he will cease to think about other women. The latter position sometimes had overtones of self-blame, as when a married woman in Savanne said,

We are women, so there's not much we can do except ask them why they have other women – is it because we don't give you enough affection that you leave us? Or is it because we have too many children? We have to talk to them in a way that touches their sensitive spot.

Most participants, however, took the stand that, in general, men do not listen. "He may listen to you once, but after that he will not listen to you," said a Delmas woman. They do not listen, explained another Delmas woman, because men never want to give up the women they have:

The other woman knows that he would never throw away the old pot for a new one. He will stay with the old one, but he will also not leave the new one.

#### **I would refuse ...**

Given the reality of sexual freedom for the men in their lives, women gave serious thought to abstinence as a solution to the risk of acquiring AIDS from a promiscuous partner, particularly

when the man declines the use of condoms. However, despite many comments that discovering a partner's infidelity would justify refusal because of the threat of AIDS, refusing sex to prevent disease still seemed to be a relatively new and even frightening idea for most women. In general, the women did not regard refusing sex as an unusual event in a relationship, but the reasons they gave for refusing a partner's sexual advances suggested that it is acceptable behavior only if it is infrequent. Common reasons for refusal emerged among all categories of participants, namely fatigue or illness, menstruation, preoccupation with financial or other household worries, and argument between the partners. Women also cited pregnancy prevention and disaffection, abuse and neglect as reasons for at least trying to avoid sexual contact. A Savanne woman in a *vivavek* relationship described using sexual favors to bargain:

If I need something and my man does not give it to me, I will not make love with him. He has to give me what he wants for me to do it.

Using sex as a bargaining tool was not limited to women in unstable relationships. Women who were *maryé* or *plasé* stated that they also might refuse to sleep with a man who was not supporting them adequately, especially if money were going to another woman. "If I need something," said a married woman in Delmas, "I ask my husband for the money, and if he doesn't give it to me, I will not make love with him. Then he gives me the money right away."

For other participants, their sense of responsibility to the conjugal relationship made it unthinkable at first to refuse a partner, but when the risk of AIDS entered the discussion, the same women often reversed their position. However, unlike fatigue, illness, anger, and even family planning, AIDS risk as an excuse to avoid sex is not under the woman's control and carries no assumption that the relationship will soon return to normal. Consequently, even women who recommended refusing a promiscuous partner recognized the liabilities. Although they were quick to advise Joujou to refuse René's sexual advances while he was seeing other women, they readily acknowledged that it was a dangerous strategy that was likely to backfire. They were saying, in effect, that in principle a woman has a right to refuse sex for fear of contracting AIDS, but in reality her right may not be recognized by her partner.

The following dialogue from a group of women in Delmas illustrates some of the fears that many participants expressed in discussing a woman's right to refuse sex:

*Moderator.* If the woman refuses to have sex with her partner, what might be the reaction of the man?

He will think you are having an affair with another man.

The man will have some doubts. He will say "If I'm your husband and you refuse, you must be having an affair with someone else."

Yes, and he will treat you badly.

He will probably say to you, "If you can't have sex with me at home, then get out of the house! Go live with that other person you have."

He will surely think I have found another man, and he will curse me. He will leave me.

If the man wants to have sex and the woman refuses, he will think that's the worst thing you could do to him. The home will be divided.

**I know that I send him to the streets ...**

The greatest fear that women expressed was that in refusing sex they would send the man back out to the streets to find a more compliant woman who would infect him with HIV, which he would then carry back to the woman at home. In another Delmas group, the women agreed that refusing sex amounted to little less than a death warrant for themselves.

*Moderator.* If a man wants to make love and the woman is not in the mood for sex, what can she do?

That happens to me sometimes, and I know that I send him to the streets, but sometimes you're just not in the mood. When that happens, he tells me he doesn't care, because there are other women and I shouldn't be jealous.

When I'm not in the mood for sex, I, too, send my man to the streets to get AIDS and bring it to me.

People say that when you like the skin, you should like the seed. In these times you have to accept when your husband says, "Let's make love."

*Moderator.* What do you mean, "in these times?"

I mean now that there is AIDS in the streets.

I agree with you. If the man wants me to make love and I refuse – and that happens to me sometimes, too – I just think about what happens in the streets and I accept.

Women feared other reprisals, too, including physical abuse and loss of spending money for food and clothing.

You can refuse the man, and for a whole week he will not give you food or pay the rent. He might tell you that you have other men who are feeding you.

Right now I will not refuse for sure, because with bad weather out there, food and water aren't easy to find. I don't have the strength to carry such weight.

Physical retaliation was a reality shared by some women, particularly the women in Savanne, as the following exchange between two married (*plasé*) women illustrates:

When men want to sleep with you, you can't refuse. If you try, they force themselves on you, and you know what has happened before, so you do what you have to. I have already experienced that.

I have a man living with me. As soon as I stop breast-feeding the babies, he always gets me pregnant, but if I refuse to have sex I get beaten up.

These women were caught in a deadly dilemma. They knew all too well the danger of sex with a man who may have numerous other partners, but the decision to protect oneself they felt would only compound the risk. There was a strong sense that women must inevitably accede to men's sexual desires in order to protect themselves and the welfare of their children. The retaliation that many women feared may have seemed a greater and more immediate risk than the threat of HIV infection itself. It is not surprising that when women talked about saying no to sex for fear of AIDS, they usually suggested deception rather than direct confrontation with a promiscuous partner. At these times, women proposed using familiar excuses such as child spacing, feeling unwell, or "needing a break," usually with the emphasis on temporary indisposition. Some said they would tell a man they were refusing because he had too many partners, but such a direct assault took more courage than many women apparently had.

## **Condoms**

### **I heard them say you can protect yourself with condoms ...**

On the question of condoms, participants were divided on several issues, namely the acceptability and effectiveness of condoms for HIV prevention, a woman's right to ask a partner to use them, and the kind of response that women anticipated from men. Without exception, women knew that condoms are supposed to prevent HIV transmission, and most accepted it as fact. But some questioned whether even a condom would be sufficient protection if the man were "already infected," also suggesting that a man might somehow carry and transmit the disease *without* his being infected. Their confusion may stem from incomplete knowledge of the difference between asymptomatic HIV infection and AIDS, which many had seen and could describe in vivid detail. Others, fearing transmission through saliva, doubted that condoms would be adequate protection. A more significant number questioned the quality of condoms and the possibility of perforation or tears. However, according to focus group participants, an even greater deterrent to condom use was women's own perception that condoms were injurious and decreased sexual pleasure.

### **I have a problem with condoms ...**

Although most women initially advocated condom use as the only solution to sex with a promiscuous partner, at least half in every group later pointed out the liabilities of condoms, sometimes with reference to personal experience. The following segments illustrate the negative attitudes that participants expressed in response to the moderator's question, "Are women in general willing to use condoms?"

(Delmas women, never employed)

Some will not agree. They say the condom is greasy. It is not good.

Women say it is greasy and there is no sensation.

They say the condom stays in their vagina.

Some people can't tolerate the smell of the grease. They get nauseated. That happened to me.

I don't use condoms because I don't know whether they are good for me or not.

(Savanne women, stable relationships)

I don't like condoms. They are nasty, but because my man has other women, I have to use them. The condom has a kind of grease that can stay inside your body.

You can also get diseases from the condom.

*Moderator.* What kind of diseases?

The condom can give you cancer inside. If it stays in there and you don't go to the doctor, it just gives you cancer.

I don't know, because I don't tolerate people using condoms with me.

If a man asked me to use a condom, I would not agree, because I am not used to them.

(Savanne women in *vivavek* relationships)

(All) condoms are uncomfortable.

When it is in, you have no feeling. When it comes out, it is full and it rips.

There was a woman who used a condom and it stayed inside her body. She had to be operated on, and she died.

I personally don't use them. I'm scared of the grease that's inside.

In contrast to remarks of women in the above three categories, women who had been factory employees were less negative. Factory workers related similar complaints they had heard about condoms, i.e. lack of pleasurable sensation, tearing or retention, and harmful effects of "grease," but they did not seem to identify to the same degree with others' negative attitudes.

When speaking for themselves, some cautioned that condoms might not be enough protection, referring to factory defects and tears. As one woman said, "I will not use condoms if I know he has the disease, I will not have sex with him at all. I will leave him."

### **I wouldn't like to use a condom, but ...**

Despite their reservations about condoms and personal objections to using them, women in all groups repeatedly and emphatically advised Joujou and others like her to tell their promiscuous partners to use condoms – or move out.

If I were that woman (Joujou) and the man is seeing a lot of women out there, I would tell him to use condoms so that I don't get the disease and leave my children behind.

The admonition of this Delmas woman was echoed many times over in every group in all participant categories. Their message was that condoms may have their disadvantages but that they are the only way a woman can continue a sexual relationship with a man who refuses to give up his other partners. Strategies for convincing a man to agree to use them varied from tactful persuasion to ultimatum. Two women factory workers offered the following advice:

If you talk to the man with courtesy and love, he may agree, but if he doesn't want to, you can't force him.

You start to call him pet names (*bagay, lobey*), even if you don't usually, and you tell him the condom will be good for both of you.

Savanne women appealed more directly to the man's responsibility for the consequences of his own behavior:

You call the man to you and you say, now that there's a disease out there, when you go out – and I don't know where you go – you must use condoms. It's protection for me and you.

If it's Maxim, I will force him to use them. He'll agree, because I'm the one who is going to bury him, and burials are expensive.

Other women said they would bargain with the man, offering sex if he used condoms and threatening to sleep in a separate bed or leave him. Several would discontinue a sexual relationship but without neglecting their usual domestic responsibilities. For many women, a man's refusal either to give up his extra-marital activity or use condoms was reason to abandon him, despite the economic consequences for themselves and their children.

### **Any woman has a right if she knows he is fooling around ...**

How do these women resolve the inconsistencies in their often contradictory perspectives on condoms? Sometimes the same women who advocated condoms for women at risk later

expressed personal fear and rejected the idea of using them in their own relationships. The answer may lie in their discussion of whether women have a right to ask a partner to use condoms. This question invariably stimulated vigorous debate on the kinds of women who have – or do not have – such a right. Differences of opinion within groups were greater than differences between participant categories, but even within groups there was little differentiation with age, education, marital status, or other sociodemographic characteristics. Responses tended to follow a pattern in which women at first agreed that any woman has a right to protect herself from AIDS but then began to raise stringent conditions under which "any woman" could properly propose condoms. A minority stated flatly that "you will never find a woman who would ask the man to use condoms." The factory worker who offered this comment went on to explain that if the woman is his wife at home, she might suggest condoms as contraception "if you are making children too quickly." If it is "another woman" who is living promiscuously, "she would not ask, because she does not care about his life." Her solution in that case was to advise the man with a wife at home "to buy condoms whenever he is going to have sexual contact with another woman."

Most participants supported the right of at least some women to ask partners to use condoms. A criterion on which most agreed was that she be certain of her risk. Women commonly responded that the woman who has a right is the one who knows that her husband has other partners, or the corollary that if the man is not "fooling around" she will never ask, as in the following comment by a married woman in Savanne:

If the woman knows that her man is frivolous, she is right to ask him to use a condom, but if she has no proof of that, she shouldn't ask him.

Other women who have a right to ask are prostitutes and school girls, neither of whom, participants pointed out, would wish to be burdened with children. Women who do *not* have the right are those in long-term relationships or whose husbands or regular partners are not seeing other women, women who are recently married, and women whose partners might wish to have more children. Several women observed that Christian women do not bring up the subject of condoms, because Christian men do not have affairs with other women. Only one woman, a participant in Delmas, volunteered that she would avoid pregnancy to protect the child if she thought either she or her husband had AIDS.

Two common elements that stand out in these criteria are sexual freedom and fertility, traditional values now threatened by the risk of AIDS. Women who question a partner's fidelity may be challenging the validity of the double standard that has governed their relationship. An irony in the *rules* that determine a woman's right to ask for condoms is that women often do not know – and are not supposed to know – whether their men are frequenting prostitutes or having affairs with other women. But in fact, a woman in a *vivavek* relationship said that "there are no women who should not ask men to use condoms, because there are no men who do not 'fool around'."

### **He can do planning with his wife ...**

Fertility was another competing value that often overshadowed disease prevention as a priority in decisions about sexuality. First, it was apparent that the link between condoms and

contraception was more familiar than the link with disease prevention. Second, while focus group participants tended to deny women the right to ask for condom use if their partners desired children, they frequently turned to the rhetoric of family planning to find culturally acceptable metaphors to justify the use of condoms for AIDS prevention when children were not an issue. For example, in response to Joujou's fear of contracting AIDS, the women often advised her to use "planning," a reference to condoms as a contraceptive barrier method which they knew also prevents transmission of the HIV virus. They felt it easier to convince promiscuous partners to accept condoms under the guise of family planning than to confront the more threatening issue of AIDS prevention.

### **Men who are not beasts will agree ...**

As the above suggests, women do not take lightly the public health prescription to use condoms as a precaution against AIDS. They understand and can accept in principle the preventive value of condoms, but there are costs that for many outweigh the benefits. Aside from their own misgivings about condoms and their safety, women were skeptical and even apprehensive about the reaction of men to such a proposal. In focus group discussions, they were quick to recommend that Joujou – and women in general – should demand the use of condoms if they could not trust the fidelity of their regular partners. However, when asked how the same men would react, their opinions varied from the firm belief that "men who are not beasts" will agree, to an equally strong insistence that few if any men will ever be willing to use condoms, especially with wives or regular partners.

### **They don't want to use condoms ...**

Women who took the more negative stand on the issue of partner response to condoms were more numerous and more vocal. For the most part, their concerns centered on issues of denial and trust. They contended that men refuse to admit having other partners and instead turn the blame on the women at home. Men want to know why they are being asked, whether it is because the woman, herself, is sick or because her own behavior is putting him at risk. Women focus group participants said that suggesting to a man that he use a condom provokes him to accuse her of having "other husbands," the only reason, he might allege, that she would make such a demand. If he wishes to take her request for condoms as evidence of infidelity, he may then respond with physical abuse, withdrawal of economic support, or abandonment.

### **If a woman works, she does not submit ...**

Fear of physical abuse was not a major theme, but fear of abandonment or economic neglect was. In the Haitian society we studied, women could be manipulated by men who had the power to deprive them of the resources for basic survival. Men who did not get what they wanted could retaliate by withholding money for food, rent, clothing – even child care. Many women expressed their powerlessness to change sexual behavior in terms of their dependency on satisfying men. Women who do not work have no right to make demands; women with jobs earn that right because they have other options for themselves and their children. Commenting on the story of Joujou and René, a married woman in Savanne said:

If the man is making money and you are not, he never pays much attention to you, but if both people are working, the woman is worth something. I have experienced this in my own house, and I realize my husband would not treat me the way he does if I had a job.

A Delmas woman echoed these words when she said, "Every decision a woman makes depends on the money she has in her hand. If she does not work and the man does, he will always be the head of the family." "A woman can decide only when she works," agreed another in her group. "Otherwise they (men) call her useless."

Comments such as these take the problem of AIDS prevention to a more fundamental level, to the direct link between women's fear and frustration in the face of the epidemic and their sense of powerlessness to control their own lives. For the women in these focus groups, money was as much a symbol of freedom as it was a material resource for achieving independence from male domination. Without access to income, they lacked the self esteem and the financial security to be full partners in critical decisions that could determine their chances of survival in the AIDS epidemic.

#### **Then he will be without a partner ...**

Even despite the awesome prospect of women losing what little economic security they may have had, many participants still believed that if a man with other partners rejects condoms, a woman should refuse sex or even leave him. There were many references to sleeping in separate beds or on the floor. When a group of Savanne women agreed that wives should be able to insist their husbands use condoms, they kept abandonment as a last resort:

Yes, you can ask him to use condoms if, in spite of all the talking, he can't make up his mind between you and the other women and if he still wants to make love with you, even though you sleep on separate beds.

If he doesn't want to (use condoms), the woman should leave him for good, because he's involved with bitches and wants to give her bad diseases.

Many such threats were expressed in all participant categories, even from some of the same women who had voiced concern that men would respond with anger and retaliation. Some said that being alone would be preferable to the risk of AIDS and that women who found themselves in that dilemma should try to find domestic work or street vending to support themselves. It was clearly a painful issue and one which illustrated the women's struggle to resolve the contradictions inherent in an old way of life that has left them with the personal resolve but neither the material nor the psychosocial resources to act effectively against AIDS.

## **2.5 Men's Perspectives on Women's Rights**

### **2.5.1 Household Decisions**

#### **If there is understanding in the home ...**

The topic of women's rights met an ambivalent response in the men's groups. With respect to household duties, most men reacted negatively to the story of Joujou's extreme dependence on René's authority for such everyday decisions as cooking and child care. Once a man gives his partner money for household expenses, they said, she has the right to decide how to spend it, provided that she *carries out her responsibilities to his satisfaction*. However, examples participants gave to illustrate men's satisfaction belied their support of women's rights to make even ordinary housekeeping decisions. Decision-making frequently seemed to mean compliance on the part of the woman rather than actual independence. Even in the matter of preparing food, there were overtones of sexual subordination of women, as in the following dialogue from Savanne:

I don't agree with what René is doing, because it is the woman who cooks. She is the one to know what to cook, depending on the amount of money you give her.

If René gives the money to cook, he has to decide what to cook that day. She cooks what he asked, because he wants to eat what he wants.

Sometimes René's decision is okay. After a good night's sleep they make love, and the following morning he can decide he wants a nice meal, a good glass of juice. That kind of decision is good, but it is bad if he does it every day.

I agree, because when you sleep with your wife at night, in the morning you have a nice meal, but during the night you have sex with her, and René can say, "Cheri, what will we eat tomorrow? Well, cheri, we will eat this food." Then they wake up the next morning, René puts the money on the table, and his meal is prepared. When he finishes eating, he will caress her hair. "Cheri, the food you gave me is good. We will make love later."

Statements in support of joint decision-making were similarly couched in terms that suggested that men are supposed to make the decisions and women to agree. Decisions which men believed should be made together in this fashion were use of a family planning method, whether and where to send children to school, and with whom their children should associate. There was some debate over whether a woman had the right to take a sick child to the clinic in the man's absence. While, in general, men wanted to be consulted about a service that required payment of a fee, opinion favored granting her the authority to act in emergencies with the understanding that she would inform him of her actions at a later time.

A Delmas man, who believed that a woman should make her own decisions about children's health care, however added that men tend to assume authority because women expect it of them:

Sometimes men become the chief of the household because of the woman. Even if you try to decide things together, she always has it in her mind that your decision comes first. Whatever you do is right. Of course, some women who are authoritarian don't do it like that, but they think they are supposed to give you the right to act.

### **2.5.2 Sexual Freedom and Women's Rights**

#### **If she realizes ...**

There was remarkable correspondence between men and women in their views on women's rights to protect themselves from HIV infection, to refuse sex, and to ask that the partner use a condom. Many men spoke of monogamy as an ideal, but they also accepted multiple sexual relationships as a fact of life, at least for men. In both Savanne and Delmas, male participants seemed to take for granted a double standard that grants sexual freedom to men and denies women the right to question their partners' activity. They frequently prefaced their remarks with "if" clauses, "*If* the woman suspects her husband has another woman ..." or "*If* she realizes that you live dangerously ...," implying that it is not normal for women to know about their steady partners' sexual affairs but that they sometimes find out.

Some of the men in Savanne expressed resentment at women's objections to their partners' extra-conjugal affairs. "The only problem that I see between men and women at home," complained a 28-year-old man in a *ménage* relationship, "is that the woman is always against the fact that her husband has affairs. She would like her husband to stay only with her."

The comment of a Delmas man illustrates the thinking of many men on male responsibility for transmitting HIV to women who do not necessarily know their partners are at risk. He explained that men can infect their wives, because,

When the woman (wife) thinks that her husband has only her, she will not have an affair with another man, but the husband's mistress may have other men, and those men will contaminate her."

Participants were well aware of the chain of transmission and men's position as the link between HIV-infected women and women at home. However, they were also anxious to preserve their independence without one woman interfering in their affairs with another. A Savanne man with a stable partner (*maryé/plasé*) explained how he would attempt to control such a dual relationship:

I can decide to have another woman. I can give that woman certain conditions. I can tell her, "My wife does not know about our relationship. If you let her know, and you tease her when you pass her in the street, I will leave you."

#### **You can't trust women ...**

On the other hand, men were also emphatic that the woman they define as a "wife" or "principal partner" has no right to have other men. Men as well as women tended to speak from personal experience on many of the issues under discussion, but men were less likely to

believe, or to admit, that their own wives might be unfaithful. When they alluded to the possibility of their own wives' infidelity, they did so in terms of a man's power to control a woman's behavior. This finding is in contrast to the remarks of many women that they (or women like themselves) could not trust their men, knew little or nothing about their partners' extra-marital activity, and felt powerless to control their behavior outside the home.

Men expected "loose women" (*fem lib*) to have multiple partners, but this norm did not apply to the woman who by law or by custom has agreed to exchange sexual fidelity and domestic labor for a long-term relationship and the economic protection that such a relationship traditionally offers. Men sometimes warned, however, that even in these more stable relationships, women were in need of surveillance and discipline. Witness this response from a Savanne men's group to a moderator's question concerning types of decisions that "belong to" men:

It is normal that if I have a woman at home, I keep her from having sex with another man. You can decide that. If she has sex with another man, I will leave her or I will beat her. She can have sex with a man for 10 gourdes, but she buys 10 gourdes of AIDS. She gives me the disease, and I will give it to others. So it's for me to decide about her having sex with another man.

*Moderator.* Do you have to beat her?

It depends. If I speak to her several times and she agrees ... but some women are frivolous.

There are some decisions that are fundamental, because the man is the master and the king of the house. Whatever he says is right. As soon as he comes home from work, he calls everybody in the house to inquire what happened (while he was gone). He also talks to the neighbors to find out if his wife had sex with another man or was involved in anything.

Some men are rough with their wives. I think I would have to find out for myself if it is true.

I think you have to respect the woman just the way you respect yourself. You can keep your wife from having sex with another man, but (if you treat her that way) you don't respect her. This is why I don't agree with you that you should beat her. You are not the master of the human being.

### **2.5.3 Women's Right to Refuse Sex**

The extent to which women are able to control access to their bodies is obviously a critical element in their capacity to protect themselves from contracting AIDS. Men debated the circumstances under which a woman should have the right to refuse sex and the range of reactions she might expect to experience from male partners when she did refuse. Sharp differences of opinion polarized these discussions, highlighting the struggle men have to resolve a basic contradiction between their right to demand compliance and the right of women to refuse.

### **She has to resign herself ...**

One perspective, more common among men in Savanne than in Delmas, was that women who are well treated by their partners actually have no reason to deny them sexual gratification. Their use of words like "joy" and "understanding" highlighted the importance of personal relations and material well-being in the conjugal agreement. The following comments from men in Savanne offer an illustration:

The man is the master of the house. He commands. Once he asks the woman to have sex, she cannot refuse, because there is joy and there is money in the house.

(Agrees) The woman is human, but if there is understanding in the home, she can never refuse to have sex. You can have sex with the woman, because even if she does not feel happy about it, she has to do it anyway.

A Delmas man reasoned that, to avoid problems in their relationship, a woman should accept her man's right to have other sexual partners on occasions when she does not want to engage in sex herself:

If the person loves you, then just to avoid a problem – because that (not having sex) creates the problem – she can say to herself that if she treats you like that, you can go out with another woman. She has to resign herself – to accept.

### **She has the right to refuse ... sometimes ...**

For the most part, however, men in both Savanne and Delmas tended to grant women the right to refuse sex – under certain conditions. Some men who expressed a relatively compromising attitude maintained, for example, that "you have to try to understand the reason she refuses" (Delmas). A few men even conceded that "just as a man does not feel like making love sometimes, the woman also has a right not to feel like it" (Savanne). However, a more central position, particularly in Delmas, was that there are certain circumstances that justify a woman's refusal. Fatigue, ill-health, menstruation, and family planning were the most commonly mentioned but often with little enthusiasm, as when a married Delmas man agreed that working hard all day might be an acceptable excuse but that "if the woman is not tired, has no work to do, there is no reason to refuse." Men also cited hunger, unhappiness, and financial neglect as reasons women can sometimes refuse, but they resented what they perceived as manipulation on the part of women:

Sometimes the woman could be hungry or not have money to eat or buy things, and woman is an animal with ambition. If you give something to her and she likes it, you can have sex with her every night, but if you don't give her something and she is unhappy, you can't touch her.

You can give from A to Z, but once you have another woman, she will refuse to make love with you.

Although men made little direct reference, positive or negative, to women's economic dependence, they acknowledged the unhappiness of those who feel neglected or abandoned by men seeking their own pleasure. A vivid description by a man in Savanne illustrates their awareness of this problem:

Another reason a woman can refuse to make love is that sometimes her husband works and she doesn't know what he is doing with the money. She thinks he is having fun with it. She thinks he is spending his money outside and can get AIDS and infect her. Meanwhile, she is dying from hunger at home, she knows that her husband is spending money, but she doesn't get any, and when he comes home she has to make love to him.

### **Women have the right to refuse, but ...**

Even though participants tended to agree that most men would overlook a partner's occasional refusal, their comments also offered numerous examples of valid objection by a man to any such decision on the part of a woman. Frequent disclaimers such as, "Women have the right to refuse, *but* ...," revealed the difficulty men were experiencing as they struggled to resolve competing issues of freedom and responsibility. There was clearly a limit to most men's tolerance for sexual rejection.

The woman has the right to refuse, but if I want to make love, I will do it anyway. If she refuses, I will say, "Cheri ...this or that," I will run outside to get her a soft drink, I will caress her. There is no way I would not have intercourse.

If she really is in love with the man, she has a responsibility. And why does a man go out with a woman? It is for affection and other things. But if I offer to make love each day and you tell me it is impossible, I will pressure you.

Transcripts from Savanne indicated a greater tendency on the part of some men to use force, or at least forceful persuasion, with an unwilling partner. As in their response to women they suspected of infidelity, Savanne men were also more likely to condone or suggest violence in the case of a woman refusing to accept sexual contact. Their remarks reflect different degrees of coercion, with only a fine line separating the force of persuasion from undisguised violence.

The woman may have a reason for not making love that day, but men have secrets (to make her) accept anyway.

Even if she is not feeling well enough to make love, once you touch her, she tells you to put it on.

I will caress her until she obeys, because this (refusal) may bring division in the home.

Occasionally, Savanne men took a harsher stand, arguing that some men understandably react to women's resistance with violence, sometimes in a manner that suggested rape.

*Moderator.* And if the woman refuses, how will the man take it?

If he has a real erection, if he wants to make love and she refuses, I would slap her in the face.

When I start to caress my wife and she refuses, I want to fight with her. If I caress her and she still refuses, I become angry, because I am excited. She may refuse, but I can fight.

Once the woman is on her back, everything is all right. In the fight, you can force your way in. She will have to accept.

**If her husband has sex with any kind of woman ...**

Refusing sex because of a partner's promiscuity provided a different kind of justification from refusal for some temporary indisposition like menstruation or fatigue. Almost without exception, men in both Delmas and Savanne concurred on the danger of sex with multiple partners and agreed that women have a right to protect themselves from AIDS at any cost, including anger and even retaliation from a possibly infected partner. In fact, the story of Joujou led many men to advise her to leave René, or at least to refuse sex, rather than risk the disease:

Joujou has just one choice. If she loves the man and she cannot leave him, she has to decide not to have sexual contact. That is the real decision. She has to feed him, raise the children. If the man is not wicked, he will give money to buy food for the children and pay the school fees.

Numerous allusions to the "other women" of supposedly faithful partners reinforced the point that a great many men were aware of women's concern about the threat posed by their partners' sexual freedom, as in this Savanne man's comment:

The woman can refuse to make love with her husband if she notices that he has sex with another woman. She thinks about how in this time when many diseases exist there is the disease called AIDS. She might think that if her husband has sex with another woman he could get AIDS from that woman and give it to her. It could be the cause of her death. She could take the precaution of avoiding sex with him that day.

This comment is significant for several reasons. First, it represents the view of most male participants that when women discover that sexual contact with their partners puts them at risk of contracting HIV, they are right to protect themselves. Even men who earlier had condemned the woman who refused sex for what they considered trivial reasons, when the issue was redefined to include the possibility of HIV transmission, later reversed their position. Second, the issue of refusal now takes on a temporal dimension. The speaker above seems to suggest that the woman's decision to refuse sex is relatively recent, linked to the appearance of a new disease and a fear that did not exist in the past. Third, the phrase "she can avoid sex with him that day" raises a question about participants' understanding of transmission. Similar comments

of both men and women in other groups suggest that some people still do not fully appreciate the nature of the risk.

### **Then who is responsible ...?**

Although many men believed that women had a right to refuse sex with a promiscuous partner, these men also warned that this strategy could backfire, lead the partner to accuse her of infidelity, and give him reason to return to his other women. While arguing in favor of a woman's right to reject such a partner, a Savanne man also added,

Many men do not feel that way. If the man wants to have intercourse with a woman and she refuses, he could think she is having fun with another partner.

Several others expanded on his point, reflecting the opinion that refusing sex ultimately threatens the stability of the whole family:

If the man feels like making love and the woman does not, he can go and have sex with anyone and get AIDS, which he can bring into the home, and everybody, including the newborn, will get it.

The family can be destroyed when the husband leaves his wife because of sex. He can think that she has sex with another man, and because of that he could slap her, even kill her. Yet the woman may be refusing for another reason, not because she has another man.

Later in the same discussion, two other Savanne men summarized the following very common approach to the problem:

If I tell the woman that I feel like making love and she doesn't agree, well! I will go out! Then who is responsible that I get AIDS? She is, because I am not used to living with another woman, I am used to living with her.

Yes, women tell their partners, "It is because of this woman that I don't have sex with you." But I know that if I had a woman at home and I touched her at sunset and she refused, she would give me the opportunity to have another woman. If she thought I had another woman, she should caress me. Then if she had sex with me willingly, I think I would forget the other woman.

There was a strong tendency for men to resolve the issue by *increasing*, not decreasing, sexual contact. Their rationale was that if the woman at home pays more attention to his needs, the promiscuous partner may forget his other sources of sexual pleasure. The number of times they proposed such a solution suggested that blaming the wife or primary partner for creating the problems that lead to HIV infection is a familiar response for many participants. Their logical conclusion seemed to be that a woman who refuses sex is increasing the chance that her partner will become infected by other women. By resuming the customary role of compliant, nurturing wife, she supposedly solves the problem with no cost to domestic harmony, helping

to preserve the balance of power that sustains a man's sense of freedom. This perspective is, of course, analogous to the anxiety which women in this study frequently expressed concerning the retaliatory behavior of an angry or dissatisfied partner who "can always go to his other woman."

#### **2.5.4 Condoms**

##### **Joujou will have to get a condom for René ...**

Discussion of condoms provoked controversy among men, just as it did among women. In general, men viewed condoms as an unfortunate, but sometimes necessary, alternative to giving up one's sexual freedom. Men were emphatic that Joujou in the story had a right to insist that René use condoms, although some men advised that she take the safer course and leave him. Some said that Joujou would have to obtain the condoms herself, while others believed that it was René's responsibility. As discussion moved from this hypothetical situation to real life as they perceived it, the men expressed differences of opinion on most condom-related issues, e.g. their reliability as protection against HIV, women's rights to ask men to use them, men's reactions to being asked, and women's attitudes toward using them.

Like the women, most male participants recognized the value of condoms in AIDS prevention, but some questioned their dependability. They were less concerned about perforation, however, than about the fit of the condom and the possibility that it would come off during the sexual act. Some explained that men risked contact with infected sperm if the man should lose his erection, and therefore the condom, before he withdrew. The majority of men advised that Joujou insist on condoms if René continued his affairs with other women. Sometimes men mentioned this as a first strategy for Joujou, but more often they saw it as an alternative to leaving him if she were unwilling to take that step. Some believed that if an AIDS test confirmed that René was HIV-infected, Joujou should leave, because "whether he uses condoms or not, if René has it, she can die if she has sexual contact with him." This comment was made by a 25-year-old man in two unions (*plasé* and *vivavek*) who had six children. The same man said he thought insisting on a condom would probably be enough to make René decide to give up the other women. Several other men agreed with him that, if Joujou has discovered René's risky behavior, then he must choose between "breaking with the other women or using condoms" because "if he cannot live only with one woman he has to take precautions." Many, however, took for granted a man's need to have more than one woman, and therefore his responsibility to accept the use of condoms, as in the following remark by a Savanne man in a *vivavek* relationship with one child:

If the man cannot leave the other woman – maybe he has children with her and two with his wife – he has to stay with both. He will have to use condoms.

##### **There are times when she can not ask her husband ...**

Despite the fact that condoms seemed to provide a reasonable alternative in such situations, men were divided on the rights of different categories of women to demand that their partners use them.

"What kinds of women can ask a man to use condoms?" the moderators asked each group. The first response was usually a comment such as, "every woman has the right to ask," because "condoms save lives and protect you from having children" (Delmas). In discussing the matter further, however, most men revealed their ambivalence, including the prior condition that a man should already have the number of children he wants.

Like the women in the study, male participants frequently combined contraception and disease prevention in their remarks on condoms and sometimes shifted the focus of the discussion from AIDS to family planning. The Creole word, *planin*, was often substituted for the word, *kapot*, or condom. Not surprisingly, they appeared more at ease putting the emphasis on contraception, rather than disease prevention. In fact, several men suggested that a woman who is trying to convince a partner to use condoms will be more successful if she uses the argument that having fewer children will enable them to provide food and pay school fees for those they already have. And it would be *inappropriate*, they said, to use condoms if the couple did not already have "three or four" children.

Thus, in the eyes of men, women who wish to avoid pregnancy have an unquestioned right to ask a partner to use condoms. Several men in different groups cited school girls who do not want to get pregnant because their parents would discover their sexual relationships. This example was used often enough to suggest that adolescent girls are a familiar source of sexual entertainment for older men. A 40-year-old married participant in Savanne explained:

My wife at home cannot ask me to use condoms, but sometimes you sleep with a young girl. This young girl can ask you, because she doesn't want to get pregnant and have problems with her parents.

As the above quote implies, men were seldom willing to give women in long-term relationships the right to ask for condoms, except for family planning. The prototype of the woman who was *not* entitled to ask was:

... a woman who is yours, who lives honestly, and does not have children yet. Now, she will not use condoms at all, and she does not want you to ask her to, whatever the circumstances.

Sometimes participants referred to the man's outside sexual activity as allowing his regular partner the right to demand condoms "if he has extra-marital relationships." A Savanne man said that his wife can ask, because "she knows that I don't have sex only with her." However, most remarks on this topic suggested that the longer the union, the less power women have to initiate behavior change, because conjugal expectations are stronger and women therefore are under more constraint to ignore their partners' extra-marital behavior.

In addition to school girls, prostitutes, and women in bars, other women with multiple partners were also entitled to insist on condoms. For such women, fidelity may or may not be an issue, but a wife or long-term partner who suggests using condoms will, by so doing, shatter the "understanding" that has sustained their union. To raise the issue seemed to many men like an admission of guilt. A woman who has "good behavior" and is faithful and respectful in the presence of her husband will not ask, because she will not want him to think she is HIV-infected or has another man. Men commonly remarked that if one partner brings up

the subject after many years in a stable relationship, the other will have a right to begin "asking some questions, since we are not used to using condoms."

### **2.5.5 Negotiating Change**

**He could realize he is poison in the home...**

When they believed the woman has a right to ask for condoms, male participants generally expected less resistance on the part of men than did female participants. In both Delmas and Savanne there were men who said that some men who should use condoms would refuse but that others who had more than one partner would comply *if* their partners used discretion and tact to convince them. A married Delmas man thought that shame might be a motivating factor in René's decision to reform his risky behavior for the sake of his home life:

I think that if René puts himself in the place of every man, he might realize that he is a poison in the home. When his wife discovers he has sex with every woman and refuses to have intercourse with him in order to protect herself, he should not do what he used to do outside anymore.

The success of strategies for convincing their partners seemed to depend heavily on a woman's skill in communicating the message that, since "there is AIDS out there," her man will have to take precautions if he wants to continue their relationship. Male participants constructed messages like the following, playing the role of the woman to demonstrate how she might influence a male partner:

The woman can often talk with the man. She should say, "Cheri, I love you. AIDS is a plague. It destroys lives. If we should stay together and you cannot live only with me, you will have to use condoms." That's what she has to say, because she can't just throw the man out.

A Delmas man offered similar advice in response to Joujou's discovery that René had other women:

The way I see René, Joujou has to educate and collaborate with him, tell him, "Well! I will practice contraception (*planin*). I will take you to the health center to get condoms so we can live." René may refuse, but if Joujou is wiser than he, she must talk to him, advise him so that he can follow her and find protection.

The above comment again reflects the blurred distinction between disease prevention and contraception, illustrating how participants, both men and women, used family planning terms as metaphor for disease prevention. A few men even suggested that if it is a man who is trying to convince a resistant partner to accept condoms for protection, he should use the argument that he does not want more children – a strategy similar to one which was proposed in some of the women's groups.

Many men claimed to believe that with soft words and firm resolve a woman can induce a man to reflect on his lifestyle and consider a change. Avoiding the necessity of a condom may be sufficient incentive, they said, to convince a man to give up other partners. Or, he may be willing to use a condom if the alternative is losing his primary partner. In either case, the participants were drawing on their knowledge of women's bargaining skill to make the point that at least some men can be convinced. A 42-year-old Delmas man who himself maintained both *plasé* and *vivavek* relationships offered his opinion that:

René will have to do some thinking about his life. He will realize that he has to live with one woman and he cannot have intercourse with prostitutes anymore. If he has a wife who offers him condoms, it is because she knows that AIDS is a plague.

#### **A playboy is born a playboy ...**

Participants alluded occasionally to distrust and the fear of disclosure that a woman might cause by raising the question of condoms, but the possibility of inciting anger and retaliation were mentioned much less often in discussion of condom use than in similar discussions of refusal to engage in sex. Nevertheless, male participants expressed some doubt as to the sincerity of men who agreed to use condoms. "A playboy (*vagabon*) is born a playboy," said a married man in Delmas. The danger he saw was that:

... even though the woman tells a man to use a condom, he will still have his other women. Someday he will cheat and have sex with his wife without it.

In Savanne, a 26-year-old man in a *ménaj* (casual) relationship told his group that some men might appear to agree, but

... they are so smart they will puncture the tip of the condom. The woman will not know, but some of the sperm will get into her.

#### **Some women don't like condoms at all ...**

On the other hand, a number of men gave examples of women's resistance to condoms. They were well aware of women's reasons for disliking or distrusting condoms, namely the decrease in sexual pleasure and their fears that the condom will break or remain in the vagina or that the lubrication will cause disease. It was not clear whether the men shared these beliefs, but almost none of them volunteered complaints of their own. They focused instead on women's resistance. Several men told stories of girlfriends who had refused condoms. Others explained that fear of raising suspicion about her own behavior might make a woman decline a man's offer of protection. Another line of reasoning, expressed by a young unmarried man in Savanne, again demonstrated the interplay between disease prevention and family planning:

When the man asks the woman to use condoms, she may think that he does not want to have children with her. Some men may have sex with a woman only for pleasure. The

woman may think that he does not want to have children and (will not) continue to support her.

A married man in Delmas pointed out that condom use should be a joint decision, even if the man first has to convince his partner:

At the beginning of this discussion we talked about decisions the man and woman can take together. Well, using condoms is a decision that we will make the two of us. Now, she can refuse in the beginning, but when you prove to her by "A plus B" why we have to do it, we can come to an understanding.

This participant's approach was different from that of most men, who were more likely to emphasize confrontation than collaboration. Nevertheless, it is *not* inconsistent with the majority point of view that men have to compromise if their wives discover their sexual exploits, a position which may herald a shift toward greater willingness to accept joint responsibility for preventing AIDS.

## ***2.6 Communicating AIDS Prevention to Others***

### ***2.6.1 Counseling Children and Adolescents***

**They are in danger, but they don't listen to you ...**

Many of the issues that arose in discussions of adult risk resurfaced when the women talked about the risk of HIV in the lives of young people, specifically girls and boys in the 14- to 17-year age range. Women across all participant categories were unanimous on two points: AIDS endangers children, and parents have a responsibility to talk with them about sexuality and prevention. A third area of common ground was that whatever one tells them, young people do not listen, that they behave as they wish. Although the focus group guide phrased questions in gender-neutral terms, there was a tendency on the part of women to talk about girls rather than boys, perhaps suggesting the extent to which they viewed AIDS prevention as a women's issue.

As parents, women attributed the high HIV risk young people run to a variety of causes, first of which was the tendency of adolescents to have several girlfriends or boyfriends and therefore multiple sexual partners. Participants complained that parents often do not know if their sons and daughters are sexually active, because the children hide their activity from parents and, if asked, deny sexual contact. A *vivavek* woman in Savanne with six adolescent children commented that young people

... can ignore their mothers, who are religious. They sleep around with many husbands (sic.) and say they are going to church and school.

Another Savanne woman, also the mother of teenagers, said:

Young women these days are like rubber bands (*se elastik*). You can't be sure they are not involved in something (*pa nan bagay*). You can spoil them, give them diamonds – they become loose (*gen tan pedi*) right before your eyes.

This mother's use of the word "diamonds" may have been metaphorical, but women in Savanne were especially conscious of the pressure that poverty imposes on young women to accept sexual invitations in exchange for gifts. When the moderator asked a Savanne group to elaborate on why they thought young people were at risk, several explained:

They are in danger because they are young ladies. They want beautiful jewelry, beautiful this, beautiful that. It's bad if their mothers are poor, because then they might take the plunge.

The child can come this afternoon wanting beautiful shoes, beautiful panties, and the poor woman can not give them to her. The girl may then go live anywhere.

Sometimes the child wants to continue school but can't because her mother can't help her.

The last speaker did not specify whether or how the girl would find her own school fees, but the implication was that, like clothing and jewelry, money for school can be had for the price of sex. In another Savanne group, the women warned that 15-year-olds contract AIDS from older men who seduce them with gifts of jewelry. Basic subsistence was also a concern. A 24-year-old woman in Savanne with 12 years of school who lives in a *vivavek* (*ménaj*) relationship herself explained that some girls are more at risk because

... they don't have husbands of their own. They might have children, but the children's fathers don't take care of them. They live with other men who give them five or ten gourdes a day. They can easily catch the disease (AIDS).

While poverty and unscrupulous older men were believed to be root causes of adolescent promiscuity, some of the Savanne women made a distinction between "good" girls and girls who "are born to fool around." If a girl does not have promiscuity "in her blood," she will not compromise her behavior for material gain, but if she does, "you go through a lot of misery."

**If she wants it, she may do something bad to get it ...**

Women who equated poverty with sexual risk also defined protection in terms of how much a parent can give her daughter, as in the following segment from a dialogue in Savanne:

*Moderator.* What do you think you could do to help (sexually active adolescents) avoid disease?

If you have the means and the child needs shoes, if she needs a dress, if she likes your earrings, you hurry and give them to her. (Otherwise) if she wants something she'll do what's bad to get it.

*Moderator.* Does this mean that if you hurry to give her everything she wants you might be able to help her not catch AIDS?

As long as you can afford it.

I'd rather stay without a dress so that I can give my child what she needs. I tell her, "My child, it isn't easy out there. There is a disease out there called AIDS."

I talk to her about ethics. I say, "My child, please cheri, ask me for anything you need and I will give it to you. If you are going out, tell your mother where you are going."

Since participants directed most of their remarks on adolescent sexuality to the behavior of girls, there were too few comments on male behavior to demonstrate gender differences in norms of sexuality. Perhaps their preoccupation with girls was an indirect reflection of permissiveness toward boys' sexual activity or of their greater protectiveness toward girls. A 23-year-old Delmas woman remarked that since "girls are more fragile," it is especially important for parents to talk to them about sex. Another young Delmas woman observed ruefully that boys claim "they are playboys (*vagabon*), that they are young and should have several girlfriends."

#### **You teach them morals ...**

Largely due to the AIDS epidemic but also because of the risk of pregnancy, all groups said that adults have a duty to warn children of the dangers they face and teach them to protect themselves. There was wide agreement that along with factual information about AIDS, young people need strong encouragement to lead a "moral" life. "We'll teach them values," said a 34-year-old female factory worker with three children in their teens, a reference to the adult ideal for adolescent behavior, which they defined mainly in terms of school attendance and sexual abstinence, or at least a monogamous relationship with one friend. Many participants said they would advise young people to "be careful" or "take precautions" but without specific reference to the means. With gentle probing, moderators often elicited more detail, such as to "talk about how it is out there and advise them to mind their schoolwork and not go to men's bedrooms (*cham gason*)."

A *vivavek* woman in Savanne with three teenage children said,

If she is in love with a young man, she should hold on to him. If she leaves him to look for another one, she is looking for disease. You have to tell her not to go to dances or stand on the street.

#### **I'd rather give her condoms than bury her ...**

Opinion on condoms was divided, but most participants said they thought sexually active adolescents should be advised to use them. As a Savanne mother said, "I would rather give her condoms than bury her." And a 23-year-old Delmas woman with three young children said, "I have already had one burial; I will tell my child to use condoms." Their tone of resignation reflected the conclusion of many women that once teenagers have experienced sex, they will

not stop. The parents' only alternative, therefore, is to give them condoms along with advice to beware the dangers of promiscuous sex.

**If you give her condoms, she'll think she has freedom ...**

On the negative side of the issue was a smaller concentration of participants in Savanne who would *not* advise adolescents to use condoms. None in Delmas opposed giving condoms to young people. Although fewer in number, the antagonists were equally emphatic that condoms were not an appropriate strategy. "Even though they may look mature," said one of these Savanne women, "they are not yet mature enough for sexual freedom." Other women who opposed condoms did so on the grounds that abstinence is more important and that the mother did not "tell me such things." The 28-year-old mother of five young children said:

If I don't know whether my child is involved in anything and I tell her to use condoms, I might as well just let her live like a prostitute (*lagel nan jenes*).

**I would tell her everything about life ...**

Frequent allusions to the importance of modeling proper conduct suggest that participants were highly aware of the positive influence that parents might have on the lives of their children. Although there was little direct reference to negative role modeling, a Savanne woman commented that "in the old days they used to say that what mothers do in front of their children, children will do themselves." "Telling children about life" was a strategy proposed by several women for discouraging frivolous behavior. Speaking from her own experience, a Savanne mother of four in a *plasé* relationship offered the following advice:

I would tell her everything about life, explain to her how I live. I would not live a bad life in front of her so she can follow in my footsteps. I would tell her, "My child, I'm going to sit you down and tell you what's in a man. Once you have a child, he may not take care of you or the child. Once you've had the child, you go through hell to raise him. I am going through misery to raise you. I am telling you these things so you will know there's nothing out there."

Although nearly everyone had an opinion on what parents should tell children about sexuality and AIDS, on the other hand there was strong agreement in all participant categories that children do not listen to adults. The women saw this fact as the single most important barrier to protecting sexually active young people from HIV. Parental advice, they felt, was often treated with disrespect. A segment from a dialogue in Savanne illustrates their concern:

Nowadays, young people only talk to each other. If you are a mother, your children will curse you for trying to talk to them (about AIDS). They'll say, "You don't know anything, old woman, trying to talk to me this way." They think they are more important than you.

Some say AIDS is only a political thing and doesn't really exist.

You can't talk to these young people.

*Moderator.* Whom do you think they would listen to?

No one can talk to them. At that age the boys already know about AIDS, and even the young girls are saying they won't use a condom, because it has a greasy substance.

Some of the women suggested that adolescents could be advocates and counselors for each other, but most participants cited health personnel, especially doctors and nurses, as the most appropriate people, along with parents, to give advice on AIDS. With probing from the moderator, there was usually someone in the group who added that any well-informed person might provide such a service – if the young people will only listen. A 36-year-old Delmas woman whose oldest child was 12 years old said that "(sex) education should not be done in one place. It should be done in school, at home, everywhere." This mother also said she would "rather talk with children than advise them to use condoms."

### ***2.6.2 Networking and Communication among Women***

**When I go for family planning I'll ask ...**

On the topic of communication among women, there was a common denominator of opinion across participant categories and within groups. It was apparent that in both Delmas and Savanne, women not only knew where they could get information about AIDS, but were talking among themselves about what this disease is and how to avoid it. In all categories except women factory workers, health professionals were the most commonly cited source of information, along with health facilities and family planning clinics. Delmas women who were, or had been, employed in factories were somewhat more oriented to non-formal sources such as friends and neighbors, but all participant categories recognized knowledgeable lay informants. Other sources were radio and television, but as one Savanne woman complained, "the radio tells you a little but not everything." Their greater emphasis on face-to-face communication may be more important to the women than radio or television.

**When two women meet, they talk ...**

Women talk about AIDS a lot, they said, particularly among close friends and family and when they are engaged in familiar activities. The following dialogue from a Savanne group illustrates their preoccupation with the disease:

*Moderator.* When do women most often talk with each other about AIDS?

When they have something important to tell. When they have time on their way to work.

When they go to fetch water.

When they are talking about important things, or with my neighbor, while combing my hair we may talk about AIDS.

On our way to fetch water, or when we go to the market, we talk about it. We say that we don't know when the man is going to give it to us. We say to each other that we should protect ourselves in order not to get it.

When a person in the neighborhood is sick, we talk to each other about it, we say that no one knows what's wrong with this person and that he might have AIDS. Then the conversation becomes interesting and everyone talks about the person.

Many factory closings in the months prior to the focus groups had left men and women with more time to talk and reflect on the meaning of AIDS and on the circumstances in their lives that put them at risk. "With nothing to do and no jobs," said a Savanne woman, "we gossip a lot." A Delmas woman commented that women who are friends talk "when they do not get along with their husbands, and in the conversation they end up talking about AIDS."

Women often referred to knowing or seeing people with AIDS as an increasingly common event and one that impressed on friends and neighbors the seriousness of the disease. They spoke of the pain they feel when someone with AIDS dies, but like the Savanne women above, their remarks carried a sense of alarm, revealing a need to share with others the meaning of an event with upsetting implications. Addressing a similar question, a Delmas woman said,

They talk. They may talk about how some person has AIDS. There are many people who have already died. How about that person who came to visit the other day? He died of AIDS. He contracted it and that's why he died. You can talk to people about that.

A few participants proposed people with AIDS as good sources of information, and a Savanne woman suggested that those who will not listen to advice about prevention should be taken to a hospital to see for themselves what can happen.

#### **If I am the woman's friend, I can tell her ...**

As they aired their views, participants consistently cast themselves in the role of counselor and friend to other women, constructing situations in which they would attempt to rescue a friend from danger. Frequently the situation involved the hypothetical friend's husband or partner, who had been visiting other women without the knowledge of his wife. In other situations, the rescuer warned her friend not to have so many partners herself, but to protect her life and her children by settling down with one man or getting a job so that she would not be dependent on men. The latter argument is illustrated in the following excerpt from a 40-year-old former street vendor in Savanne:

I would tell my friend to stop having an irregular sex life and find some work to do. There is all kinds of work out there – working as a maid in a private home, working as a street vendor, anything she can do to put an end to that kind of life.

A group of women in Savanne talked about what helping other women meant to them:

If I know the woman's husband is fooling around, I'll tell her so that she can take precautions. I'll tell her to talk to her husband and to use condoms if they are having sex.

I may talk to her if she's doing something wrong, too. If her husband has other women or she has other men, I would tell her that's how she can get AIDS.

I can help other women in many ways. I can talk to them and tell them that everybody's talking about a new disease called AIDS.

If I am the woman's friend, I can tell her that she's doing the wrong thing, that her husband is straight and that she will give him AIDS if she fools around. If it's the man who is fooling around, I will tell the woman to be careful.

Another Savanne woman volunteered the following illustration to explain how one friend might help another:

When two women meet, they talk about the disease. I will say, "My dear, the AIDS disease is out there. I have this friend I have been sleeping with (*sevi avel*), but I don't know if he has been sleeping with other women. I will break away from this relationship." I don't know if the other woman will do the same, but this disease calls for caution. There is no cure.

**We feel sad, because we are women, too ...**

Most participants related easily to this discussion, constructing vivid images of women like themselves attempting to communicate to others an imminent danger and a need for change. It was very clear, however, that from their perspective, talking about AIDS in the everyday world had problems and liabilities. Women talking to other women about AIDS is upsetting, they said, because it raises anxiety and forces them to deal with such uncomfortable issues as the sexual behavior of a trusted partner or the possibility that their own behavior may be threatening their lives. When participants discussed how women feel when they talk about AIDS, they identified a broadly significant barrier to AIDS prevention, namely the emotional impact of confrontation with the reality of the disease, including their powerlessness to change that reality without dramatically altering other aspects of their lives. Whether the participants felt competent to deal with these issues outside the protected environment of a focus group was hard to judge. Nevertheless, they were almost unanimous in their agreement that talking about AIDS makes women very uncomfortable.

The moderator's question, "How do women feel when they are talking about AIDS?" elicited strong responses. A 27-year-old Delmas woman with three children and no stable partner said:

When a woman talks to me about AIDS I feel so frightened that I think I should live by myself and never have a man. But now life does not come that way; you have to have a partner.

The following segment from another Delmas group illustrates again the twin specters of fear and doubt that such discussion raised:

We don't feel good when we're talking about AIDS. If you get it, you could die.

We are scared because the woman might have no other friend, but her husband could have another woman, so she lives with doubt.

Once you have a problem and you start thinking about it, you never feel comfortable.

Barriers to communication also arose from the perception of others' response to women who try to initiate a conversation about AIDS. A group of Savanne women shared the following example:

A woman might talk to another about AIDS if she knows this woman is a good person, but if she is a bad person, I would not discuss it with her.

*Moderator.* Why would you talk to her if she is "good" and not if she is "bad?"

The good person would listen, she would think it's for her own good, but the bad one would think I want to discuss AIDS because I don't have any financial problems.

What she said is true. Some people even curse you if you talk to them about AIDS.

If the woman is fooling around and she is my friend, I will tell her to stop so she won't get AIDS. But there are some who will curse you. They will say you don't understand, because you don't have their financial problems, and if you did you would never refuse the little money that a man offered you.

A former factory worker in Delmas said that "you just can't give advice to some women; they get upset and tell their husbands." A Savanne woman reflected similar experience when she said that you can tell another woman about preventing AIDS, but "she may get angry and say you are telling her she is going to catch it." Others reported different reactions: some people don't believe what they are hearing until it's too late; some believe that women who talk about AIDS do so only because they have it; and only loose women or prostitutes talk about such things. There is another kind of woman, one participant said, who will suspect that a friend's warning about her husband's risky behavior is a strategy to take the man for herself. At the end of one of these exchanges, a woman in Savanne added her opinion of the real reason, "... they keep talking about it because they're scared."

### **Even if the person gets angry, I tell her anyway ...**

Despite the negative reactions they anticipated from some, women in the focus groups seemed willing, and even eager, to talk with others about AIDS, although with some reservations, as the following segment suggests:

I don't feel uncomfortable when I'm talking about it. If the person gets angry, I have to tell her anyway. I understand.

I wouldn't feel uncomfortable, either, if she's family or friend, but if I don't know the person I wouldn't talk to her about AIDS.

Another woman in the same discussion indicated that if she had knowledge about AIDS, she would expect to be paid for disseminating it to others if they were not her friends. "I can not talk to (just) anyone," she said, "because they won't all react the same way." This participant was the only one in all the groups who suggested payment.

### **What happens to one can happen to all ...**

Most women spoke as individuals, but still they seemed to feel a sense of collective responsibility for a problem too great for most individuals to manage. Participants talked about warning other women of the dangers of sexual freedom, about exposing men who "fooled around" with "loose women," and about sharing information and strategies for preventing transmission. Their readiness to talk to others, despite the risk of being misunderstood or rebuffed by some who might resent the intrusion, suggested a sense of urgency. And when women spoke of their "responsibility" to help friends in difficult and risky sexual relationships, they were expressing a latent sense of solidarity that as yet had little form. Most women had no formal group affiliation, because few such groups exist in Haiti. The clearest articulation of an abstract sense of collective responsibility came from a 38-year-old Savanne woman who had no formal education but belonged to a prayer group in her church. She expressed her concern about preventing AIDS in the context of her religious beliefs when she said,

I think that all of us on earth are brothers and sisters, because there is only one God who is the Father of all of us. Each one should tell another (*bri kouri, nouv l gaye*). If you know about the AIDS disease and that it has no treatment, you have to tell others.

The same woman advised the others in her group to talk about prevention before it is too late:

It's not when a woman is sick that you should preach to her, it's starting from when she is healthy, because the disease has no treatment. When you sleep with a man and take money from him, the money can't cure you. It's when we're healthy that we should talk.

The moderators raised the issue of collective support with a question, "How can women help other women to have more strength (*plis jaret*) in the way they live with their men?" It was a difficult concept for the women to grasp. The few who responded did so in terms of advising

others on well-known modes of HIV prevention, specifically monogamy and condoms, or they referred vaguely to helping another person "maintain a normal life for herself." A group of women in Delmas answered the question in terms of a more general role of marital advisor:

If your husband treats you well in the home, you could talk to your friend and ask her how her husband treats her – we all can have hope.

Our support (*jaret fos*) can help a woman in the way she lives with her husband. But all homes do not function the same way. If the man doesn't give her money, you can't advise her on how much she should get, but you can give her support and tell her how to get along with her husband so he will love her and take care of the children, who won't grow up living promiscuously, and so he won't go around living with other women and fathering other children.

**If someone explains it to me, I will teach another ...**

Toward the end of each focus group discussion, moderators asked participants if they thought women in general would benefit from talking about AIDS in small groups. Not surprisingly, the answer in most groups was positive. However, the *vivavek* women in Savanne were unenthusiastic, saying, for example, "We don't belong to groups" and "The sister who gives us condoms tells us how to avoid disease," probably referring to a nurse or health assistant from a clinic. In other participant categories, the question elicited discussion of ways in which women might organize AIDS information meetings with neighbors, friends, or co-workers. The following segment from a dialogue in Delmas illustrates their response:

We would benefit from a group like this one by having a gathering at someone's house so we can talk.

We must invite people.

You hear talk about AIDS, but you don't know what AIDS is. You know there is AIDS out there. If a woman is fooling around (*vivavek*) with many men, we must tell her to avoid AIDS. I came here and said all that I understand, but I still can not explain how the AIDS disease is. But if someone can explain it to me, I can teach another.

Women frequently spoke as if they believed they were in an AIDS education meeting, even though the moderators began every session with an explanation of their role as listeners, not teachers. Nor is there any indication in the transcripts that moderators were giving information about HIV. Nevertheless, women made comments like, "When I get home, I'm going to share what I've just learned here" (Savanne). Although the purpose of the focus groups was not education, many women probably did learn something about AIDS, but they were learning from each other. Because they were ready and eager for new information, they perceived themselves as learners and accepted the contributions of their peers as information they needed to have. Unfortunately, not all the information they received was accurate, but their confusion

drives home the point that women urgently need a forum in which to sort out fact from fiction and discuss with others the impact of AIDS and AIDS prevention messages on their own lives.

## ***2.7 Summary and Discussion of Study Objectives 1-8***

### ***2.7.1 Knowledge and Beliefs about AIDS: Objectives 1-2***

**Objective 1: To establish the knowledge base of study participants concerning AIDS transmission, modes of prevention, and sources of information.**

Men and women who participated in the focus groups for this study were well acquainted with AIDS, some from first-hand experience, others as a result of AIDS education messages presented by the mass media and by health workers in clinics and community outreach programs. Informal networks are also a source of information on AIDS, which, according to study participants, has become a common topic of discussion among women.

In all focus groups, participants agreed that heterosexual contact is the principal means of transmission, particularly if either partner has other partners who may be infected. They were aware of the way that disease spreads in a sexual network and spoke of the danger to the woman at home who may not be engaged in risky behavior herself nor be aware of her husband's or regular partner's other sexual activity. However, participants seldom acknowledged perinatal transmission, except when moderators asked women specifically whether they felt a responsibility to protect unborn children. A few answered in the affirmative, indicating that they knew of the risk to the fetus, but they showed some confusion over whether transmission is from the mother or the father. This topic generated little discussion, unlike the effects on children left destitute when parents become ill and die of AIDS. Concern for the welfare of such children was an important issue to many participants and a prime reason to alter sexual behavior in order to protect the mother's health.

Understanding of HIV transmission by means other than sexual contact was linked mainly with participants' perception of blood as a channel for infection. When they discussed causes of AIDS, they referred repeatedly to blood transfusion and contaminated needles in clinics and hospitals, although these were of less concern than heterosexual transmission. A minority of participants said they believed kissing was dangerous because of the transfer of saliva through dental cavities or through cuts or sores in the mouth. A few also warned that menstrual blood from an HIV-infected person may contaminate washing and drinking water, that mosquitoes may carry and inject infected blood, and that eating the meat of an AIDS-infected animal may cause the disease in humans. Casual household contact with infected people, for example sharing eating utensils, sitting in the same chair, or using the same toilet, was also believed by some to endanger other members of the family. It must be noted, however, that these distorted or incorrect notions of HIV transmission occurred with much less frequency than more accurate statements about sexual transmission and even blood transfusion. Moreover, whenever such misconceptions were voiced, at least one other group member usually contested the assertion and then provided a more accurate explanation.

In this study supernatural causation emerged as a relatively minor factor in participants' views on HIV transmission. One explanation may be that the increasing visibility of AIDS, along with a wider dissemination of HIV prevention information, is leading people to redefine

the disease in a more natural context. However, this finding is contrary to other recently reported data which indicate greater popular belief in a supernatural explanation of the AIDS phenomenon. Thirty-seven percent of respondents to the 1989 Child Health Institute KAPB Survey professed belief that AIDS could be transmitted by an evil spirit (9). Researchers in the Cornell-GHESKIO Project also found strong evidence of a supernatural perspective on cause among both male and female HIV-sero-positive patients in an AIDS counseling unit in Port-au-Prince (6). Although fully 60 percent of these patients directly acknowledged or "did not deny" the possibility of supernatural transmission, the authors of this report point out that the strong taboo associated with discussion of voodoo ritual in Haiti probably results in under-reporting of supernatural beliefs about AIDS. In the present study, the question of supernatural transmission was never broached directly; participants were asked only the open-ended question, "As far as you know, what causes AIDS?" A few individuals in the present study alluded to voodoo ritual, but fear of disclosing personal beliefs on a taboo topic may have prevented others from offering their opinions.

The participants' generally high awareness of sexual transmission, however, was reflected in their knowledge of prevention. They displayed near unanimity on the value of monogamous relationships and condoms in blocking the spread of the virus, although some participants, both men and women, expressed doubt that condoms would be adequate protection. They also knew that condoms are available in health centers, family planning clinics, and pharmacies. None of the participants ever alluded to scarcity or difficulty obtaining condoms. Whether or not they actually made use of these sources, focus group participants believed they knew where people could find them. However, despite the frequency with which women proposed condoms as the best, and sometimes the only, effective barrier, many said that they as well as others believed condoms were harmful. Most often cited were concerns about the ill effects of the lubricating gel and the fact that a condom might break inside them, both of which possibilities they saw resulting in female genital disease and possibly death. While common in the discussions, such statements were usually countered by other participants who did not share these beliefs and were able to provide more accurate information.

Differences of opinion surfaced within groups as to whether a woman whose partner was at risk of contracting and transmitting AIDS should attempt to persuade him to change his behavior, to refuse sex, to ask him to use condoms, or to abandon him entirely. Persuasion was usually the first strategy, but participants were about evenly divided over whether a woman should then refuse sex or demand that her partner use a condom. Abandoning an uncooperative partner was generally the final solution, even though for some women the economic cost of losing a partner outweighed the gain in health protection. In any case, the focus group discussions supported the conclusions of the 1989 AIDS KAPB study that Haitian men and women are relatively well informed about AIDS, its transmission, its prevention, and the availability of condoms.

**Objective 2. To identify women's understanding of the seriousness of HIV infection and their attitudes concerning personal vulnerability.**

Participants were acutely aware of the seriousness of AIDS and the consequences of the disease for children whose parents are infected. They saw severity in terms of the inevitable suffering and death that they associated with AIDS-infected individuals. They spoke frequently

of the disruption of family life when a breadwinner can no longer support dependent members. Of particular concern to them were the needs of children for food, clothing, and school fees, as well as their moral upbringing if left alone and without parental guidance.

When asked whether "women like themselves" were at risk of getting AIDS, many participants responded candidly, confessing to being uncertain as to the sexual affairs of their own husbands and regular partners outside the home. Their feeling of vulnerability was compounded by their awareness that men may not recognize the danger of AIDS in other partners who could be infected but appear to be healthy. *Vivavek* women, the least likely to be living with stable partners, expressed particular concern, and some of their comments indicated recognition of the danger inherent in their own free lifestyle. Participants in all categories emphasized that if neither partner "fools around" (*viv deyo*), they are not in danger, but there was also general consensus that many women are at risk because their men are unwilling or unable to confine their activity to a single partner. Some of the women in *maryaj* or *plasaj* relationships testified to their own partners' fidelity, while others admitted frankly that they did not know. These observations help to explain the findings of the 1989 KABP study that, despite their knowledge of HIV prevention and low reported behavioral risk, women tend to perceive themselves as highly vulnerable.

Although virtually all participants took the attitude that women in general are at great risk of acquiring HIV and many expressed personal fear, there was a strong countervailing tendency among women in stable relationships to deny their own vulnerability. The attitude of these women was that, having only one man, they had nothing to fear. Some added that their spouses also had no other partners. Still others seemed to believe that once a man gives up his promiscuous lifestyle, it is safe to resume a normal sexual relationship with one stable partner and without considering the need for protection. There was obvious confusion among the women as to the risk they inherit from a partner's previous sexual experience. There was also a striking contradiction between the complacency of women who expressed belief in their own partners' fidelity and the equally strong assertion that men are accustomed to sexual freedom and can not be trusted to behave responsibly outside the home. These contradictory attitudes and beliefs were symptomatic of the confusion which appears to accompany the realization that the old rules of sexual behavior can no longer be taken for granted.

### **2.7.2 Sexual Norms as Perceived by Women: Objective 3**

**Objective 3: To identify women's perceptions of the norms that govern sexual decision-making and behavior associated with the risk of HIV/AIDS.**

This study has examined the question of women's rights with respect to the division of authority in household matters and to sexual decisions which influence the probability of HIV transmission. Although most women claimed autonomy in certain household tasks such as food preparation and child care, they did not always agree on the locus of authority in sexual matters. Some said that both partners "decide when to make love," but most said that while women may have the right to initiate sex, they seldom had the right to refuse. Also among the decisions they believed belong to a man was the prerogative to have more than one partner. The right to have other partners was never accorded to women, although participants acknowledged that women sometimes do have affairs on the side. They made a clear

distinction between "wives," or women at home, and "other women" who live freely and are expected to have multiple temporary partners. The term "wife" (*madanm*) was used to denote any woman in a stable relationship and sometimes in the plural when referring to the multiple steady partners of one man. Similarly, the term "husbands" (*mari-yo*) was used to refer to the plural partners of a woman.

According to female focus group participants, women know that men are free to engage in multiple sexual relationships, but a woman is not supposed to know about the extra-conjugal behavior of her own partner, the man with whom she shares a home and responsibility for raising children in a long-term union, whether sanctioned or not by marriage. The man's outside life is his own business. Focus group discussions revealed how women's dependency on men for subsistence has reinforced the norm of male sexual freedom. Some participants attributed subordination of women to economic disadvantage, claiming that a woman with no earned income has less bargaining power, and therefore receives less respect, than a woman who can buy what she wishes with money she earns and controls.

At the same time, they expressed the woman's domestic role in terms of the balance and harmony ("understanding") that it is her duty to maintain in her household. Participants made it clear that their material support often depended on women's success in living up to this expectation, a constraining factor that tended to reinforce compliant behavior in sexual as well as domestic activity. The more dependent a woman is, the harder she must try to compensate for the sexual excesses of her partner. Failure to comply with the behavior expected of a dutiful wife was seen by some women as justification for the husband to seek other "wives" or temporary partners "on the street." Participants who took this stand serve as guardians of the old order insofar as they believe providing sex is as much a woman's duty as preparing food; she does not let her partner go hungry, no matter what the circumstances.

Others defended women's rights in the sexual relationship, but their comments suggested that women's rights, as they defined them, were increasingly in conflict with prevailing norms. In providing new information and attempting to change risky sexual practices, AIDS prevention campaigns have increased the tension between established norms of behavior and women's perceptions of their sexual rights. Focus group discussions revealed a sense of urgency to resolve this conflict. Although women agreed in principle on their right to protect themselves from AIDS, in practice they did not always recognize their right to take the actions necessary to achieve this end.

The issue of women's rights was not new to participants. Indeed, focus group transcripts revealed numerous instances of women asserting their right to challenge old norms of sexual behavior, with no observable differences among the four female categories. Men may be the acknowledged "masters" in most sexual decisions, but many women's comments displayed their latent power in putting traditional limits to the test. In actuality, many women do claim certain rights in a sexual relationship, primarily to refuse sex when they are "not in the mood." They tended to agree among themselves that a woman can be excused from sex if she is menstruating, tired, troubled by household problems, or feeling neglected by her partner. They believed that men, "if they are not beasts," will accept temporary indisposition as an excuse and may become more attentive to the woman's needs if they recognize that sexual harmony requires "understanding on both sides." Focus group participants also pointed out that men who have other partners have other options when the primary partner is temporarily indisposed.

Participants generally acknowledged that under particular circumstances a woman has a right to ask her partner to use condoms. To wear a condom is a decision that a man ultimately controls, but in promoting mutual responsibility for children's welfare, family planning education has, in effect, relaxed the norm of male autonomy in at least one decision that affects the sexual act. Even participants who supported a conservative interpretation of women's subordinate role in other aspects of the relationship believed that the decision to use contraception should be shared between the two partners. Women have a right, they said, to ask partners to use condoms for family planning. With no comparable terminology for a barrier against disease, some continued to use family planning terms in their rationale for granting a woman with a promiscuous partner the right to demand condoms.

The corollary also applies, that women do not have this right if the man has few or no children. When a woman insists on a condom, she says, in effect, that she is not willing to bear his children, a message that clearly contradicts basic values of procreation. Prostitutes have a right to demand condoms, the implication being that loose women should not have to bear the burden of their partners' children. Similarly, while participants did not condone sex between older men and adolescent girls, several commented that "schoolgirls" often use condoms so that pregnancy does not give away to their parents the secret of their sexual activity.

In sum, women's rights proved to be an exceedingly complex issue due at least in part to the many contradictions imposed by the AIDS epidemic on the normative structure. Belief in a woman's right to protect herself from disease ran head-on into participants' views of her responsibility to play the customary role of compliant wife, to preserve harmony in a stable relationship, and to protect her own economic base. Women were clearly confused about what their rights should be, some taking the position that a woman has a right to leave a promiscuous partner, others arguing that men are justified in seeking pleasure with other women if their wives fail to live up to domestic and sexual expectations. The one common denominator across all respondent categories was that women *deserve* the right to protect their own welfare; how to act on that right without rejecting those values which have given positive support to the conjugal relationship in the past was a dilemma that none could resolve.

### ***2.7.3 Women as Change Agents: Objectives 4-6***

**Objective 4: To assess women's beliefs in their own power to control the sexual relationship.**

As the above suggests, focus group participants were well aware that to claim their right to self-protection, women would have to confront men on the dangerous issue of sexual freedom. Moreover, as Bandura has pointed out, taking initiative in behavior change requires not only information and motivation but the means and resources to take action (12). For Haitian women to challenge the old normative order will require courage bolstered by strong belief in their capacity to exercise personal control. This research therefore explored women's sense of empowerment in terms of the strategies and the communication they believed might influence men's behavior and the range of responses a woman might anticipate from her sexual partner.

For the most part, women did not perceive themselves as powerless to control when and with whom they would engage in sex. Although they tended to accept the norms that protect

male sexual prerogatives, they believed in their ability to manipulate the sexual act even to the extent of refusing sex when they were "not in the mood." For the most part, however, their sense of control was an illusion. Exceptions to the norm of female compliance depended on temporary or easily reversible circumstances, like menstruation and mood. Women were not expected to remain indisposed, and men could always cajole the reluctant partner with affection and gifts. With the advent of AIDS, however, the stakes have gone up; women are learning that temporary relief from their sexual responsibilities will not be enough to protect them from the risk of acquiring the disease. Old excuses have to be replaced with new and more powerful interpersonal skills which will shift the balance of power to enable women to negotiate permanent protection.

Participants debated such strategies for influencing a promiscuous partner from a variety of perspectives. Those who emphasized persuasion said they would use care and affection to convince a man to stay home and at the same time explain to him the nature of AIDS and the dangers of sex with other women. Others said a woman might continue to carry out routine domestic tasks but should no longer sleep in the same bed with a man who refused to give up his "extra-marital" pleasures. Still others advised women to try to convince men to use condoms, not only with their "other women," but with their wives or primary partners at home. The ultimate strategy, if all else failed, was to leave the uncooperative partner, despite the economic hardship that might follow. Several added that working as a domestic servant or a street vendor was preferable to the risk of dying from AIDS.

Acting the part of a fearful woman, participants spontaneously role-played how to gently persuade an amorous partner to use a condom or to give up other women without alienating his affection. They stressed the need to inform him about AIDS and to explain logically how it can be transmitted. The emphasis was almost always on the danger of HIV, not on the morality of the sexual behavior. Few women made direct references to the advent of AIDS as a new disease, but by implication they were saying that now there was a new reason for behavior change that had not existed before its arrival.

Although women readily suggested ways to reduce the risk of HIV transmission, not all believed their strategies would work. Some were optimistic that, if approached with tact and understanding, men would agree with the wisdom of a different lifestyle. Others believed that the same result could be achieved with an ultimatum either to change high-risk behavior or lose the primary relationship. A majority, however, were skeptical that women could actually succeed with any strategy. They based their pessimism on what they perceived to be the reluctance of men to admit to having other sexual partners, men's refusal to give up their sexual freedom, and the social and economic costs to a woman of alienating a breadwinner. Physical abuse was not a major theme in the focus group discussions, though a few women in Savanne expressed fear of violent retaliation from disaffected partners. In general, participants agreed that to question a man's sexual freedom is difficult for any Haitian woman and will require skillful communication and the courage to confront issues of power that have not had to be addressed in the past.

**Objective 5: To explore women's sense of responsibility for promoting AIDS prevention among adolescent children.**

Whether or not women in the focus groups had adolescent children themselves, all agreed that teenagers are at risk of contracting HIV. Young people are sexually active, they said; girls have "many boyfriends;" and children do not listen to the advice of their elders. Moreover, they tend to conceal their sexual activity from parents and deny sexual involvement if confronted. Furthermore, once they have experienced sex, the women believed young people would not be willing to give it up. They all advised parents to talk to children about sex, or "to tell them about life," but the transcripts reflected an undercurrent of pessimism that parental guidance would have any lasting effect. Other adults who, in their view, might be able to educate children about AIDS prevention were doctors, nurses, and other health workers or any "knowledgeable" adult. A few women raised the possibility that well-informed teenagers might be able to inform and advise others about the disease and how to prevent it.

The women believed strongly that young people should abstain from sexual contact and "mind their schoolwork," but their comments revealed a sense that abstinence is probably an unattainable ideal. Condoms, therefore, seemed to be a necessary prescription for HIV protection. Some believed that advising young people to use condoms would only promote promiscuity, but most women, sometimes reluctantly, advised that giving their children condoms might be the only way to protect them from AIDS. However, the issues of adolescent motivation and compliance remained unresolved.

Discussions of adolescent risk echoed some of the themes that emerged in discussions of adult risk. First, the common assumption that teenagers are not only sexually active but likely to have more than one partner paralleled women's accounts of similar adult behavior, including the element of secrecy that they believe shields them from disclosure. Moreover, participants often commented that they would advise a girl at least to be faithful to one boyfriend. The fact that the women focused mainly on standards of behavior for girls leaves open the question of whether adults are more likely to condone or overlook the sexual exploits of boys. If so, then pressure on a girl to keep a boyfriend by pleasing him, or complying unquestioningly with his desire for sex, might only increase her risk, just as it does for adult women whose partners do not share their efforts to live within a monogamous relationship.

An even more striking analogue to the sexual and economic pressures on adult women was the implication that some young girls are already exchanging sex for material goods they could not otherwise afford. Women in Savanne were particularly conscious of this problem, complaining that if parents do not provide adequately for their daughters, they may get what they want from men who can. There is no way to judge the extent of this practice, but even as a potential threat over the heads of disadvantaged parents, it has serious implications. A few focus group participants with teenage children did, in fact, comment that to protect their daughters from the risk of contracting HIV, parents should accede to their daughters' wishes for things like clothing and jewelry. Thus, the economic implications of behavioral risk surfaced with sufficient clarity to show a glimpse of the suffering of parents caught between poverty and the risk of losing a child to AIDS. Such comments also shed light on the socialization of young women to the rules of sexual negotiation, teaching them at an early age that sexuality means bargaining.

**Objective 6: To explore women's sense of responsibility for promoting sexual behavior change through interaction with other women.**

Very few of the women in this study reported an affiliation with a club or other organized group which might provide a forum for AIDS information and discussion. On the other hand, they said that women do talk informally together about AIDS, mostly to seek information from others, to share their anxiety, or to tell each other about a neighbor or acquaintance who has died of AIDS. At least some participants knew that information was available from health personnel and that health centers and family planning clinics provide AIDS education and distribute condoms.

When moderators asked participants how women might help each other to protect themselves from AIDS, their primary advice was to expose the promiscuous behavior of a friend's partner, to provide reasons that a promiscuous woman friend should abandon her dangerous lifestyle, and to share prescriptions for getting along with a man so that he will not be tempted to turn to other women. Participants commonly said they would offer themselves to others as role models of success in a conjugal relationship. However, most would limit their advice to friends, relatives, and people "who will listen." They warned that there are women who might need such counseling but who resent hearing it, because they distrust the counselor or because they do not want to admit to their own vulnerability.

Even women who are willing to talk about AIDS find it difficult to do so. When asked how women feel when they talk about AIDS, most participants responded with words like "scared," "uncomfortable," "sad." They explained their emotional reaction by the fact that they did not know whether their partners were infected and by their experience of seeing people they knew die of AIDS. Yet despite the resistance of others and their own discomfort, many participants expressed an eagerness to talk among themselves and with other women about the disease, how it is spread, and how it can be prevented. They had difficulty with the concept of "collective responsibility," but their strong support for the idea of women helping other women suggested that at least those who participated in this study felt an obligation to reach out to family and friends with the ideas they encountered in the focus groups. In fact, although moderators confined themselves to asking questions and guiding discussion, many participants commented on how much they had learned, and how they looked forward to telling others what they had learned when they returned home.

**2.7.4 Gender Differences: Objective 7**

**Objective 7: To determine male-female differences with respect to norms of sexual decision-making and sense of responsibility for protecting themselves and others.**

The perceptions of sexual norms and expectations held by women were strongly validated by the views expressed in the men's groups. Female experiences and opinions were reflected in analogous accounts by men of male attitudes and behavior toward women. Many of the norms that women said made it difficult for women to protect themselves from AIDS were also documented in transcripts of men's discussions. Women expressed anxiety and uncertainty over partners' sexual behavior outside the home. Male participants spoke of the common practice of men to have other women and to guard their own sexual freedom. However

knowledgeable they might be about the consequences of unprotected sex, many women were fearful that attempting behavior change might only encourage men to increase their sexual activity with women on the outside and, hence, their risk of infecting their wives or regular partners. Men repeatedly referred to the ability of a man to find what he needs elsewhere and then to blame sexually non-compliant women at home for the increased risk. Women believed that men would allow them occasionally to be non-compliant with sex; men and women both cited the same reasons for a woman's refusal, but men stressed that she should not refuse too often. Fear of retaliatory abuse emerged from the women of Savanne and was echoed in the bravado with which some of the men from the same city threatened to punish women who refused sex for unacceptable reasons.

Similarly, both men and women believed that women have at least the right to protect themselves from contracting HIV from men who have other partners, with no clear agreement on how they could do so and escape retaliation from men who were unwilling to compromise. Male participants also debated the wisdom of several alternative courses of action, including attempts on the part of the woman to force a man to give up other partners by threatening sexual abstinence, condom use, or abandonment. Although discussion of these strategies left unresolved differences among individuals within each group, there was little gender distinction.

Communication between sexual partners received considerable attention from both men and women. Spontaneous role play of situations in which women were attempting to influence partners' behavior showed men and women approaching the same problem from similar perspectives, balancing factual information, reason, tact, and the recognition that AIDS is a new disease.

Economic issues, on the other hand, were perceived differently by men and women. Many women were acutely aware of the relationship between income-generating work and decision-making power, expressing the belief that control of money is fundamental to control in other aspects of life. Men were more likely to interpret women's desire for money as manipulative. They sometimes attributed a woman's reluctance to engage in sex to her man's failure to give her money or provide for her material welfare, but at no time did men advise women to find work or did they acknowledge the effect of dependency on women's self-esteem.

Men and women also differed in their expectations of the male response to a woman's proposing the use of condoms. Women were more pessimistic. Some expressed the belief that men would never admit the need for condoms. Others feared that partners would construe the request as evidence of the woman's infidelity and either abuse or abandon her. Anxieties such as these were validated in men's harsh comments on the problems a woman causes when she refuses to agree to sex. With respect to condom use, however, male participants expected more compliance from their fellow men. Women and men set similar conditions for granting women the right to demand condoms, i.e. desire to limit or space children, evidence of male infidelity, or a promiscuous lifestyle on the part of the woman. Given these limits, male participants expected for the most part that if women use logical argument and tactful persuasion to communicate their desire to protect the family from AIDS, most men will reflect on the reason for the request and be willing to compromise. Men tended to formulate their strategy in terms of choice. Once the woman at home discovers his extra-marital affairs, he must choose between giving up the other women or using condoms. If giving up women is unacceptable, or complicated by long-term obligations to more than one partner, he may decide that the only alternative is to use condoms.

That so many male participants were willing to come to grips in the focus groups with this difficult choice suggests that there is at least a latent sense of responsibility among men to protect themselves and others from contracting HIV. Women may express more overtly the

urgency, and therefore the responsibility, to find a solution to the crisis that virtually all have recognized, but altering old norms of interaction is not easy. Comparison of men's and women's positions on the prospect of behavior change reveals underlying differences in gender-related coping. Comments of both women and men suggest strongly that they believe it is the woman's responsibility to set the stage for safer sexual practices. "Teaching," "explaining," and "reasoning" were terms they used to describe ways that women should appeal to their men to accept disease prevention as a new way of life. Women were expected to use caresses and gentle words to communicate the harsh realities of a vicious epidemic to men who held the power to determine whether they would live or die.

This prescription preserved for men at least the illusion of their customary role as sexual decision-maker. Throughout the discussions in all participant categories there was a consensus that in the conjugal union, women possess the wisdom but men hold the power. By implication, men should weigh the merits of a woman's carefully crafted argument and decide for himself how he would respond. Men who persisted in a state of denial or disregard were defined by participants, both male and female, as deviant. They were judged in contempt of traditional cultural values that place a high premium on conjugal cooperation and harmony. The alternative choice, to accept behavior change, was positive for preventing HIV transmission and preserving "understanding" in the home but costly in terms of the man's loss of sexual freedom.

However, although both male and female participants expected women to exercise diplomacy in sexual transactions, they were not expected to be helpless. Careful inspection of the data hints at an iron female fist under the velvet glove, expressed in terms of women's ultimate recourse should reason fail. Women repeatedly threatened to leave uncooperative partners or advised other women to do so, despite the fearsome prospect of being dependent and alone. Men, too, acknowledged that women with no hope of influencing promiscuous partners to change their behavior had no choice but to leave them. This argument is flawed, however, because for many women without means of subsistence there is no middle ground between living in the shadow of HIV and destitution.

### ***2.7.5 Opportunities and Barriers to Change: Objective 8***

**Objective 8: To identify factors that may promote or hinder women's ability to influence sexual behavior.**

#### **Promoting Factors**

**AIDS Awareness.** The fact that most of the participants had a reasonably accurate understanding of HIV is indicative of the success of AIDS awareness campaigns in their communities. It also points to the growing number of people in urban areas who are experiencing AIDS through the loss of family or friends and who are spreading the word that the disease is not a myth but a clear and present danger. Although distorted and inaccurate perceptions of AIDS arose in the discussions from time to time, there was nearly always at least one participant who argued the point with correct information. Participants were also well informed on the means of preventing transmission. They knew that risk reduction means limiting sexual contact to one person and using condoms if there was any doubt about the behavior of a partner. They were aware of the availability of condoms, and most participants believed that women as well as men should be willing to ask for them. If becoming informed is the first step to adoption of preventive health practices, then people like the participants in this study are on their way to lowering their risk of HIV.

**Belief in Personal Vulnerability.** Women participants as well as men recognized the horrendous consequences of AIDS and also the vulnerability of people like themselves, despite a tendency among some women to assume that their own partners were faithful and that the AIDS prevention warnings therefore did not apply to them. Many women expressed deep personal fear that they were living with men whose sexual behavior outside the home was a mystery. A significant number of others stated frankly that they knew their husbands or regular partners had other women and were well aware that those women may have been infected yet have no signs of illness.

Fear prompted a sense of urgency as women dared propose preventive strategies that challenged the traditional woman's role in a conjugal relationship. The willingness that many women expressed to confront change, even at the risk of great economic and social sacrifice, may prove to be a critical predisposing factor in their capacity to influence behavioral norms.

**Sense of Responsibility.** Another strength that the transcripts disclosed was the sense of responsibility that many women expressed, not only for protecting themselves from HIV infection, but for educating their children about the dangers of unsafe sex and cautioning other women to behave responsibly. That is not to say they necessarily believed they could be successful in influencing others; they fully recognized the difficulty in persuading adolescents to forego sexual contact, and they acknowledged that there were women who would resent their efforts. Nevertheless, the majority of women who spoke out on issues of parental and community responsibility did so with a resolve that signified courage in the face of opposition.

**Men's Recognition of Women's Right to Protection.** An interesting finding of this study was the apparent willingness of men to grant women the right to violate traditional norms of sexual behavior, whenever necessary, to protect themselves from HIV infection. When AIDS was not an issue in the discussion, however, they imposed strict limits on the right of women to refuse sex and emphasized that such refusal must be short-lived and infrequent. On the other hand, in the presence of HIV and the risk of transmission through a promiscuous partner, men agreed that women must do what they can to avoid infection. Some men felt ambivalent about the contradiction between disease prevention and fertility, but in general, they believed that women have to educate men about AIDS and that men *should* be ready to compromise their behavior in order to protect themselves and their partners and preserve the integrity of the primary relationship. Although "should" is no guarantee of compliance when it comes to actual behavior, they were more optimistic than women participants that with the "right" strategy, women stood a reasonable chance of influencing men to change their behavior.

### Barriers to Behavior Change

**Attitudes toward Condoms.** In many different ways, focus group discussions in Savanne and in Delmas showed women ready to take responsibility for protecting themselves and others from AIDS, but several obstacles stand in their way. One is the negative association with condoms that many women still hold. According to participants, it is common for women to recognize the value of condoms in preventing HIV transmission but to reject them for their own use. Some had health concerns. They feared damage or disease if the condom should tear or come off in the vagina, or they worried about possible harmful effects of the lubricant. Others said women will not accept a condom if they believe it decreases sexual pleasure. Still others viewed condoms as a seed of discord or distrust in a relationship, capable of causing psychosocial, if not physical, damage. Women who took this position worried that for either partner to suggest condoms would raise suspicion of infidelity or HIV infection, thus destroying the relationship and the home.

**Norms of Sexual Behavior.** Focus group participants alluded frequently to networks of sexual partners and the practice of men in stable unions to have periodic sexual encounters with women outside the primary relationship. Participants acknowledged that women in stable (*maryaj* or *plasaj*) unions may also have other sexual partners, but a clear message comes through the transcripts that it is the extra-marital affairs of men which are more frequent and more likely to be condoned or overlooked.

Sexual freedom and the double standard that supports it represent deeply rooted gender differences in sexual decision-making. As Lowenthal (11) has pointed out, women have been able to control the sexual encounter up to a point by using their sexuality to bargain for things the man can provide. Men, on the other hand, who are not expected to control their own sexual desires, dominate the physical act of intercourse. Thus, normative structure has served until recently to maintain a precarious balance of power between men and women, but the formula no longer works. For women, protection from AIDS must now include negotiating monogamy and the use of condoms, two aspects of behavior that have fallen traditionally in the domain of men. As the threat of AIDS continues to erode long-established beliefs about sexual rights and relationships, patterns of negotiation will have to change and power will have to shift, or there will be no stopping the epidemic.

**Economic Dependency.** The single most important barrier to the efforts of Haitian women to effect positive behavior change is their subordinate status in the economy. The comments of several women participants highlighted directly the connection between their perceived powerlessness to influence sexual behavior and their dependence on men for subsistence. Women who have no income of their own are not respected by their partners; their opinion does not count. Women repeatedly expressed fear that attempts to protect themselves from HIV would lead angry partners to retaliate by withholding material support. Others asked, How can a woman refuse sex with a partner *unless* she has another man to support her? With little or no schooling and few opportunities for employment, most disadvantaged Haitian women have no way to earn money except as street vendors or as domestic servants who often work for less than a subsistence wage.

Many of the AIDS prevention measures which women proposed in focus group discussions depend ultimately on their ability to be economically self-sufficient. Although persuasion and bargaining were key elements in their self-protection strategy, their final recourse was to leave a partner who refused to change his behavior. Yet if a woman has no place to go, leaving home is unrealistic and as an empty threat only weakens her bargaining position. Self-esteem and belief in one's ability to influence others are critical tools of negotiation and decision-making. Possessing neither, an economically dependent woman runs a predictably high risk of contracting HIV. Until vocational training and income-generating opportunities become a reality for Haitian women, it is unlikely that the majority will be empowered to participate as equal partners in critical sexual decisions.

**Lack of Women's Organizations.** There are few formal organizations in Haiti which foster social and economic development among disadvantaged women. With the exception of a few who participated in church activities such as prayer groups, women in the study reported no formal affiliation. Yet focus group discussions indicated that informal communication about AIDS is common. Women apparently ask questions of each other, compare notes on what they know, and gossip about acquaintances who have fallen ill or died of AIDS.

A simple question as to whether participants thought other women would benefit from opportunities to discuss AIDS prevention in small groups elicited an enthusiastic response and spontaneous offers to inform others. It also revealed that even though moderators provided no information or explanation about AIDS, many respondents believed they had been in an

educational session. In point of fact, they had; but they had been instructing each other. If they are to take an effective part in AIDS prevention efforts in their families and communities, as well as in their own lives, women need to be affiliated with groups that can provide the material support and moral encouragement necessary to sustain their motivation. The concept of mutual support, whether formal or non-formal, appeared to be less familiar to Haitian women than it is to women in countries where self-help has been the basis for encouraging participation in local and national development. The lack of such support in Haiti can not help but delay efforts to empower women to gain control of their own lives and to take leadership in campaigns to stop the spread of AIDS.

### **III. CONCLUSIONS AND RECOMMENDATIONS**

#### ***3.1 Implications for Intervention: Translating Research to Action***

The final objective of this research was to identify possible intervention points for strengthening the role of women in the prevention of AIDS. Since the start of the epidemic, HIV surveillance has documented the relentless spread of the disease through urban and rural populations; AIDS prevention activities have disseminated information and education widely; and condom promotion and distribution programs have increased the availability and to a limited extent the demand for protection. Efforts to alert the Haitian people to the danger of HIV transmission have succeeded to the point that most know what AIDS is and associate condom use with prevention. Clearly the HIV/AIDS surveillance, education and condom distribution programs must continue with even greater support and determination, but they alone are not sufficient to change culturally rooted expectations of behavior which this study suggests are the real obstacles to change. The AIDS prevention campaign in Haiti must simultaneously address a fourth component, namely normative change. This approach would infuse current AIDS prevention activities with empowerment-oriented strategies which place AIDS in the context of women's sexuality and social status. The blueprint for action now must include not only informing, educating and motivating, but also *enabling*.

HIV/AIDS prevention can be realized only if men and women together come to grips with the need for change in norms which control sexual relationships and deny women the right to determine their own lives. Normative change calls for radical intervention inasmuch as it takes the problem of HIV/AIDS prevention beyond individual behavior to a societal level, where it requires basic change in cultural definitions of sexuality and gender relations. This component of HIV/AIDS prevention is difficult to actualize, but the findings of this study suggest that people in Haiti are ready to act if they have the means. Focus group participants have demonstrated that it is not so much lack of information and motivation that is fueling the AIDS epidemic in Haiti, but old patterns of sexual behavior, including the subordination of women to male sexual freedom, which contradict the messages they receive from AIDS prevention programs. We have seen a common determination on the part of men and women to survive in the AIDS epidemic, but until they are able to resolve behavioral conflict through redefinition and negotiation, neither men nor women will have the power to prevent HIV transmission.

Following are six substantive areas in which the focus group transcripts give particularly clear direction for HIV/AIDS intervention. They reinforce the value of continued preventive education while making empowerment the driving force to slow the spread of the epidemic.

### **3.1.1 Knowledge of HIV/AIDS**

Although most people are aware of the disease and know that it is sexually transmitted, many focus group participants were confused about other modes of transmission, particularly casual contact. There also seemed to be little awareness – or perhaps concern – about perinatal transmission, and some were confused as to whether infection was passed to the fetus by an infected father, infected mother, or both. Belief that the sperm carries the virus directly to the fetus might lead an HIV+ woman to think that her baby would not be at risk if the father were sero-negative. However, because so few participants commented on risk to the unborn child, it is possible that many participants simply did not know, or did not take seriously, the danger of vertical transmission.

HIV/AIDS education must also continue to help people understand the major channels of transmission and recognize false or distorted information which may lead to unnecessary concern and unwarranted discrimination against infected individuals. As cases of AIDS increase, the epidemic is becoming more visible in Haiti, and efforts to promote a realistic understanding of HIV infectiousness will be critical in preventing stigmatization and isolation of AIDS patients and their families.

#### *Recommendations:*

- That AIDS prevention programs reinforce current HIV/AIDS education by placing greater emphasis on modes of transmission, by dispelling myths concerning casual and supernatural transmission, and by increasing awareness of the danger of transmission to infants of HIV sero-positive mothers.
- That programs evaluate all AIDS prevention messages for accuracy, quality of presentation, and breadth of dissemination. Programs should pay particular attention to how individuals in the target population interpret the information they receive.

### **3.1.2 Condom Use**

Most women seemed to know that condoms are their best and most practical defense against HIV in an infected partner, but many were negatively disposed to using them. They feared breakage and contact with the lubricating gel (referred to as "grease"), which they believed were the causes of disease and possibly death. They also claimed that condoms have an unpleasant odor and that they decrease their sexual pleasure. Many believed that for similar reasons men would not use them. However, in addition to their objections to the physical properties of condoms, women complained that use of condoms threatens a stable relationship by suggesting that one partner is either diseased or unfaithful. It is inappropriate, many participants felt, for a woman in a long-term relationship to suggest condoms, although they believed that promiscuous young girls, prostitutes, and others who wish to avoid pregnancy have the right to do so. Therefore, fear of rejection or retaliation was a strong deterrent to raising the issue of condom use with a stable sexual partner.

The quality of the latex in condoms is obviously critical to an intervention strategy, but so is education to teach their appropriate use and dispel myths about condoms as a cause of disease. Moreover, AIDS prevention programs must deal with the perception of condoms as a threat to the stability of a relationship and, in many cases, to a woman's economic support. These are complex and difficult issues, but if they are not directly addressed and resolved,

suspicion and fear will continue to deny many women the right to protect themselves from HIV infection.

*Recommendations:*

- That condom social marketing programs reinforce the message that condoms are safe and effective.
- That such programs emphasize the use of condoms in stable as well as casual relationships.
- That such programs make condoms accessible through community-based distributors trained to provide realistic information and counseling.

### **3.1.3 Sexual Rights of Women**

As suggested above, the prevailing standard of sexual behavior in Haiti makes it difficult for women to take the initiative to change sexual practices that affect their partners. The findings of this study indicate that for many Haitian men and women, conjugal harmony is more highly valued than fidelity. The code of behavior which supports long-term relationships discourages women from interfering in their partners' extra-conjugal affairs or, in fact, from acknowledging that they even exist. Questioning or rejecting a man's sexual advances, the participants said, is likely to anger him, and an angry man may react by leaving the house to find a "loose woman" who will be more compliant and less demanding.

Women are therefore in a double bind with regard to their exposure to HIV: They can attempt to control a man's sexual behavior to reduce HIV risk but only at the peril of even greater risk when he goes off to sleep with other women. Or, they can continue to play the traditionally compliant, nurturing role, accepting him as he is in exchange for material support and affection – along with continued exposure to HIV.

The complex issue of women's rights in the conjugal union needs to be a focal point for intervention. Both male and female focus group participants agreed on the right of women to protect themselves from a deadly disease, but it was evident that this position ran counter to traditional expectations of behavior in a sexual relationship. HIV/AIDS prevention messages must be explicit about women's rights, sensitizing women as well as men to the actions that women have a right, even a duty, to take in order to protect themselves and their families.

This strategy will require AIDS prevention programs to incorporate opportunities for people to resolve the clash of values between old norms and the threat of a deadly new disease. Cross-gender discussion of sexual practices among adults has seldom been a component of AIDS prevention programs, but the present study has demonstrated that many men and women may be ready to work together to explore solutions to this common problem.

*Recommendations:*

- That men and women in the target population participate with AIDS educators in developing communication strategies for negotiating safe sex.
- That AIDS education include such strategies in prevention messages which highlight cross-gender communication on sexual risk.
- That communication strategies focus on both women's and men's rights in the sexual relationship, particularly the right of either to insist on condom use and to deny sex to a partner suspected of being at risk of transmitting HIV.

### **3.1.4 Protecting Children and Adolescents**

Although focus group participants were emphatic that sexually active adolescents are at risk of acquiring HIV and that parents have a responsibility to counsel children about prevention, most doubted that children would listen. Comments on how parents might help their children tended to be vague and inconsistent, indicating that it is not an easy issue. Some participants suggested that a mother's only recourse is to provide her daughter whatever she wants so that she will not be tempted to accept the gifts that older men may offer in exchange for sexual favors. The participants in this study seemed to be open to discussing sexuality with their children, but the risk of HIV imposes demands too urgent for many to deal with alone. Findings suggest that parents are ready for counsel and support in identifying and dealing with this critical issue.

#### *Recommendations:*

- That HIV/AIDS prevention programs develop strategies which address the specific needs of all children and adolescents for education and counseling to reduce their risk of acquiring HIV.
- That programs provide opportunities for parents and children to participate in dialogue about HIV risk and responsible sexual behavior.
- That health educators collaborate with parents, teachers, and students to develop school-based programs to replace traditional gender stereotypes with newer images that support healthy sexual relationships.

### **3.1.5 Communicating with Other Women about HIV/AIDS Prevention**

Women in this study expressed a strong sense of obligation to help other women avoid contracting AIDS. However, they warned that while many women are now talking among themselves about AIDS, they still find it a difficult topic to discuss because of the anxiety it raises. A woman who tries to counsel another woman runs the risk that her intentions will be misinterpreted either as slander or as an attempt to separate her friend from her partner. Nevertheless, focus group discussions indicated that some women have at least a rudimentary sense of collective responsibility, although for most of them it did not extend beyond family and close friends. The study also offers evidence of the need to provide women with basic communication and leadership skills, as well as techniques and materials for AIDS education, and to encourage them to expand and act on their sense of responsibility to other women.

#### *Recommendations:*

- That HIV/AIDS prevention efforts include direct support to grassroots women's groups where they already exist, incorporating them into a broader community-based strategy.
- That AIDS educators identify natural leaders among local women and assist them in developing techniques for reaching other women with HIV/AIDS prevention information, counseling, and condoms.
- That support for local leaders in HIV/AIDS prevention include knowledge and information, group discussion techniques, visual aids, and continuing education and supervision.

### **3.1.6 HIV/AIDS Prevention Messages in Family Planning**

Although contraceptive behavior was not a specific focus of this research, participants frequently alluded to family planning in the context of AIDS prevention. They sometimes seemed more comfortable promoting disease protection under the guise of family planning than confronting AIDS risk directly. They used the Creole term, *planin*, to mean condom and occasionally advised women to take uncooperative partners to a family planning clinic for an explanation of AIDS risk and prevention. On the other hand, few participants in the study said they currently used, or had ever used, a contraceptive method. Despite this apparent contradiction, the HIV/AIDS prevention campaign in Haiti needs to consider ways of exploiting the relative neutrality of family planning to promote responsible sexual relationships and the use of condoms for protection against HIV and other sexually transmitted diseases.

#### *Recommendations*

- That AIDS and family planning educators collaborate to examine the nature and extent of current HIV counseling in family planning clinics.
- That family planning clinics explore ways to reinforce behavior change in the context of family health, emphasizing the risk of perinatal transmission and the consequences of AIDS for children of infected parents.

### **3.2 Implications for Planning**

#### **3.2.1 Incorporating Dialogue in AIDS Prevention Education**

The intensity with which men and women entered into discussions of sexuality and HIV risk showed that they both wanted and needed a forum in which they could discuss and debate the impact of the disease on their lives and the implications of behavior change for human relations as much as for AIDS prevention. The similarity between men's and women's perspectives on AIDS risk and behavior change also suggests that many may be ready for discussion in mixed, as well as single-gender, groups. In this research, the focus group format, one which used a story-telling modification to introduce pertinent issues, was a successful stimulus for discussion. As an intervention tool, it is likely to be equally successful in engaging people in discussion of prevention strategies and helping them to resolve interpersonal problems which accompany behavioral change.

Focused discussion, moreover, has the potential to foster participation and "ownership" in the process of change and increases the probability that such change will spread and take root. To that end, modified focus groups may serve as a means to identify and train lay leaders in AIDS prevention, providing not only information, but skills for peer support and conflict resolution. The urgency to slow an epidemic which is growing out of control demands strategies to ensure rapid dissemination of techniques which Haitians at all levels can use to promote fundamental change.

#### *Recommendations:*

- That HIV/AIDS prevention programs identify and train local leadership to conduct focused group discussion which addresses information needs and the resolution of conflict inherent in change.

- That local discussion leaders receive additional training and support to enable them to disseminate discussion techniques by becoming trainers of others.
- That such training and implementation begin with support to grassroots groups already in existence.

### ***3.2.2 Story-Telling as an Adaptation of the Focus Group Technique***

The story of "Joujou" and "René" proved to be an effective technique in drawing participants quickly into the discussion while leaving them free to express their views, with or without disclosing their own behavior. Whether for research or intervention, such stories should be developed in collaboration with representatives of the target population. In fact, the transcripts of this study are rich with real accounts of personal experience which could become the basis for discussion in future groups. Properly integrated in a discussion format, stories can focus attention on critical issues in prevention which might otherwise go undiscussed and unresolved.

#### ***Recommendations:***

- That AIDS educators collaborate with people in the target population to develop a series of vignettes in the form of stories which reflect familiar issues inherent in AIDS risk-related behavior change.
- That such vignettes be pilot-tested and taped for use by trained local discussion leaders in their families, in their neighborhoods, at their workplaces and in schools, as a non-formal technique for introducing change in sexual behavior and helping people to discuss and overcome the barriers to change.

### ***3.2.3 Promoting Economic Independence among Women***

Findings of this study draw attention to the critical relationship between a woman's economic status and the perception she has of her power, or lack of power, to initiate preventive behavior. Although this relationship needs to be further explored, many women's comments suggested that women with no earning power have no power to negotiate change in their sexual relationships. The heavy dependence of some women on irresponsible sexual partners makes it unlikely that educating them about AIDS or motivating them to protect themselves will be effective in stopping the disease. HIV/AIDS prevention programs in Haiti must acknowledge economic imbalance as a fundamental cause of a gender inequality which has severe consequences for women and children in the AIDS epidemic.

#### ***Recommendation:***

- That national and international efforts to slow the spread of AIDS in Haiti also give high priority to longer-range goals of basic education and training for women in income-generating skills.

### **3.3 Implications for Applied Research**

As this research begins to clarify important issues in the gap between knowledge of AIDS and preventive behavior, it raises new questions which have a direct bearing on program development and policy for AIDS prevention in Haiti. Some of these are summarized below.

#### **3.3.1 Influence of Supernatural Beliefs on Behavior Change**

The focus group transcripts offered only hints of the widespread belief in supernatural causation documented by other studies. Reports of two recent HIV/AIDS KABP studies (6, 9) suggest that supernatural beliefs about AIDS are more common than the present study would indicate and raise the question of whether this difference signifies participants' reluctance to express views which are contrary to the official biomedical position on HIV transmission. To the extent that it exists, such under-reporting has serious implications for policy affecting the development of AIDS prevention messages. Knowledge of sexual modes of transmission will have little effect on the behavior of those who also believe that a spiritual force can target AIDS at specific individuals, while others remain immune. The co-existence in many cultures of traditional and biomedical beliefs about disease is well known to social scientists who have explored traditional taxonomies and have often observed the simultaneous use of multiple healing systems. Evidence of widespread belief in the power of voodoo to inflict AIDS, therefore, does not invalidate the finding that people know and accept biomedical explanations of heterosexual spread. What it points to is the possibility that the two belief systems are sending contradictory messages which people rooted in both traditions must reconcile in the best way they can. How Haitian believers in voodoo resolve the dissonance between supernatural and biomedical theories of HIV causation is a critical problem for research; so too is the effect these beliefs have on their attitudes toward prevention and treatment. Answers to such questions would have implications for AIDS counseling as well as for development of culturally sensitive AIDS prevention programs.

#### **3.3.2 Partner Exchange**

Although this study yielded some insight into attitudes and behavioral expectations of women in *vivavek*, *ménage*, and other non-binding extra-conjugal relationships, most participants, including women in the *vivavek* groups in Savanne, tended to direct their remarks to concerns of people in married (*maryaj*) and common-law (*plasaj*) unions. Their responses therefore leave unanswered many questions pertaining to the rules that define extra-conjugal relationships and partner exchange.

Multiple sexual partnerships are common in Haiti, but are little understood in terms of the social and behavioral factors which determine codes of sexual behavior for either men or women. Understanding the ground rules on which partnerships are based is fundamental to understanding behavioral risk in the spread of HIV/AIDS. The findings of this research suggest that male-female relationships in Haiti tend to be loose; that many men maintain the right to have both wives and mistresses, or casual partners outside the home; that women in conjugal relationships are expected to be faithful and to ignore their husbands' extramarital affairs; that men use their sexual freedom to force compliance of their wives or long-term partners; and that economic dependence can prevent a woman in any type of sexual liaison, conjugal or casual, from acting on her right to protect herself from AIDS.

There is need for studies which classify types of sexual relationships on the basis of their length and intensity; contractual exchange and the expectations of each partner; and partners' perceptions of HIV risk and responsibility for prevention. The influence of women's social and economic status on their involvement in multiple partnerships should also be carefully documented, along with evidence of their power, or lack of power, to protect themselves from contracting AIDS. Needed is a new taxonomy of sexual unions, one which takes into account the potential impact of the AIDS epidemic and new attitudes toward prevention on patterns of sexual behavior. A clearer understanding of the formation, maintenance, and dissolution of multiple partnerships over time could lead AIDS prevention educators to more effective techniques for promoting behavior change.

### ***3.3.3 Economic Barriers to Behavior Change***

Unemployment was viewed by female participants in this study as a major constraint on women's ability to influence their partners. This finding leads to the hypothesis that income-generating activity is directly associated with a woman's risk of acquiring HIV as defined by her partner's sexual behavior. Research to test this hypothesis and to measure the costs of vocational training against the benefits of decreasing the risk of HIV could have broad implications for public policy.

### ***3.3.4 Change in Sexual Attitudes and Behavior over Time***

Findings from this study indicate strong awareness among Haitians that the AIDS epidemic is changing their lives. Needed are studies to describe perceptions of change in the general population, rural as well as urban, and to document temporal relationships between various levels of experience with AIDS, shifts in attitudes toward prevention, and sustained behavioral change. On a policy level, understanding of the natural process of change could offer insight into ways that planned intervention might hasten cultural acceptance of new norms of behavior.

### ***3.3.5 Knowledge, Attitudes, Beliefs, and Practices of Adolescents***

Focus group participants expressed commitment to protecting young people against HIV but showed little sense of direction as to how they might accomplish this goal. The authors recommend in Section 3.1 of this report that AIDS educators develop specific programs to help parents and teachers counsel children to make healthy choices for responsible sexual behavior. This difficult task requires clear understanding of the perceptions young people have of gender relationships, sexuality and the relation of both to HIV. Research is needed not only on their knowledge and attitudes towards AIDS but on their sexual practices, on psychosocial factors associated with sexual responsibility, and on barriers which may prevent adolescents from protecting themselves and others. Of particular interest would be the degree of congruence between adult perceptions of their children's risk and adolescents' awareness of the dangers of unprotected sex and their willingness to accept prevention. These insights could have significant implications for AIDS prevention programs designed to foster more effective communication between young people and their parents, their teachers, and health providers.

### ***3.3.6 Communication Networks and Support Systems among Women***

This study has shown clearly the need for women to take a more central role in AIDS prevention in both their personal relationships and in the wider community. Female participants seemed ready to assume responsibility for informing and supporting others, but as yet we have little systematic information on patterns of informal communication and interaction among Haitian women. It is not known, for example, how or to what extent women support each other in domestic crises such as abandonment or physical abuse by a sexual partner. In focus groups, women spoke of warning others of their risk of AIDS, but the data gave few clues as to the effects that such warnings might have or the degree to which the advice of one woman might be disseminated to others in the household or community.

The success of efforts to draw women into AIDS prevention programs may depend on the ability of program planners to use existing networks and familiar patterns of communication to introduce new concepts of sexual behavior and conjugal relations. A grassroots movement such as the Les Cayes Committee for Women against AIDS should be examined carefully for clues to the way that women mobilize their resources in response to the threat of a new disease. In short, more research is needed to identify, describe, and promote culturally appropriate channels for disseminating behavioral change.

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## APPENDIX A

### DEMOGRAPHIC CHARACTERISTICS OF FOCUS GROUP PARTICIPANTS

<u>Savanne</u>	VIVAVEK <sup>1</sup> WOMEN n=17	STABLE <sup>2</sup> WOMEN n=36	MEN n=26
Mean age (years)	29	31	30
Mean number of children	1.9	3.9	1.7
Percent in stable union <sup>2</sup>	-	100.0	38.5
Percent in non-stable <sup>1</sup> ( <i>vivavek</i> ) union	100.0	-	61.5
Percent with no formal schooling	76.5	86.1	19.2
Percent literate	23.5	16.7	73.0
Percent Catholic/ Protestant <sup>3</sup>	47.1/ 41.2	63.9/ 19.4	76.9/ 19.2
Percent earning <H\$3 per day <sup>4</sup>	93.8	93.5	81.8
Percent with no current income	64.7	77.4	53.8
Percent with group affiliation <sup>5</sup>	11.8	13.9	38.5
Percent currently using a family planning method <sup>6</sup>	-	27.8	-
Percent who have never used a family planning method	82.4	61.1	96.2

#### Notes:

1. In this report, the term *vivavek* also includes *ménaj*, *zanmi*, and other relatively non-stable relationships.
2. A stable union is defined here as marriage (*maryaj*) or *plasaj*.
3. Voodoo was not specified but may have been concurrent with other religions or included as "other."
4. Percentages exclude participants who did not answer this question.
5. Most group affiliation was church-sponsored, as in prayer groups; others were work-related, as in fisherman's cooperatives.
6. Participants were not asked to differentiate between modern and other methods.

APPENDIX A Continued

DEMOGRAPHIC CHARACTERISTICS OF FOCUS GROUP PARTICIPANTS

Delmas

	WOMEN FACTORY WORKERS <sup>1</sup> n=27	WOMEN NON- FACTORY n=25	MEN n=28
Mean age (years)	31	30.5	31
Mean number of children	2.9	2.8	3.4
Percent in stable union <sup>2</sup>	N/A <sup>3</sup>	N/A <sup>3</sup>	42.9
Percent in non-stable union <sup>4</sup>	N/A <sup>3</sup>	N/A <sup>3</sup>	57.9
Percent with no formal schooling	33.3	24.0	10.7
Percent literate	70.4	76.0	78.6
Percent Catholic/ Protestant <sup>5</sup>	29.6/ 59.3	60.0/ 36.0	53.6/ 52.9
Percent earning <H\$3 per day <sup>6</sup>	79.2	100.0	71.4
Percent with no current income	63.0	92.0	67.9
Percent with group affiliation <sup>7</sup>	11.1	12.0	25.0
Percent currently using a family planning method <sup>8</sup>	33.3	28.0	60.7
Percent who have never used a family planning method	40.7	52.0	28.6

**Notes:**

1. Includes women currently or formerly employed in factories.
2. Defined here as marriage (*maryaj*) or *plasaj*.
3. Excluded due to data recording errors.
4. Also includes *vivavek*, *ménaj*, *zanmi*, and other relatively non-stable relationships.
5. Voodoo beliefs were not specified but may have been concurrent with other religions or included as "other."
6. Percentages exclude participants who did not answer this question.
7. Most group affiliation was church-sponsored (as in prayer groups) or work-related (as in cooperatives), political, or humanitarian.
8. Participants were not asked to differentiate modern and other methods.

## **APPENDIX B**

### **THE IHE/AIDSTECH PROJECT ON WOMEN AND AIDS FOCUS GROUP GUIDELINES (Translated and abbreviated)**

#### **Story for Discussion**

**Moderator:** Joujou is living with a man by the name of René. René is working in a factory, but Joujou is not working. Joujou has four kids at home; the oldest one is seven years old, the youngest one-and-a-half, and she is again pregnant. Before Joujou got pregnant with this last child, she wanted to start using family planning, but René did not want her to. René gives money for food in the house, but it is he who decides what to cook. When the children are sick, Joujou must ask René's permission before she takes them to the clinic.

1. WHAT DO YOU THINK ABOUT THE WAY RENE AND JOUJOU ARE LIVING?  
(Kinds of decisions men and women make together, women's decisions, men's decisions)
2. WHO MAKES THE DECISION WHEN A MAN AND WOMAN "MAKE LOVE?"
3. IF A MAN FEELS LIKE MAKING LOVE WITH HIS WOMAN AND THE WOMAN DOES NOT WANT TO, WHAT CAN SHE DO? (HOW DOES THE MAN REACT?)  
(Women's right to refuse sex, refusal strategies, partners' responses)
4. WHAT REASONS MIGHT THERE BE FOR A WOMAN TO REFUSE TO MAKE LOVE WITH HER MAN? (Women's rights under specific conditions, bargaining)

**Moderator:** There is another part to the story of Joujou and René. Let's continue it and see what happens ...

Joujou is worried. She has learned that when René goes to town, he often goes to the houses of other women whom he is having affairs with. Joujou does not know what she should do. She does not want to leave René, but she is afraid he will give her AIDS.

5. WHAT DO YOU THINK THIS WOMAN SHOULD DO? (Expectations of behavior for women at risk of HIV)
6. IF THE WOMAN DOES WHAT YOU ARE SAYING, HOW DO YOU THINK THE MAN WILL REACT? (Expectations of male response to protective behavior)
7. DO YOU THINK THAT THE WOMAN SHOULD TALK TO THE MAN ABOUT THE FEARS SHE HAS OF CONTRACTING AIDS? HOW CAN SHE BRING UP THE SUBJECT? HOW WILL HE REACT? (Male-female communication on AIDS and AIDS prevention)

8. IF THE MAN IS HAVING AN AFFAIR WITH ANOTHER WOMAN, CAN HE GIVE THE DISEASE TO HIS WOMAN (AT HOME)? HOW? (Knowledge of HIV transmission)
9. AS FAR AS YOU KNOW, HOW DO PEOPLE (IN GENERAL) GET AIDS? (Knowledge of HIV transmission)
10. WHAT KIND OF PEOPLE GET AIDS? DO YOU FEAR AIDS? (Transmission, belief in severity, sense of vulnerability, personal fear, appearance of HIV-infected people)
11. WHAT ARE THE CONSEQUENCES OF THIS DISEASE FOR THE FAMILY? (Knowledge of the disease, belief in severity)
12. IF A WOMAN KNOWS NOTHING ABOUT THIS DISEASE, HOW CAN SHE GET INFORMATION? WHAT DO WOMEN WANT TO KNOW? (Formal and non-formal sources of information, desire for information)
13. (WOMEN ONLY) DO WOMEN TALK TO EACH OTHER ABOUT AIDS? WHEN? HOW DO THEY FEEL IN THESE DISCUSSIONS? (Nature and circumstances of informal discussion, emotional responses to discussion, level of interest)

**Moderator: The woman in the story (Joujou) is afraid that her man may give her AIDS, because she knows that he is having affairs with other women ...**

14. HOW CAN SHE PROTECT HERSELF? HOW WILL THE MAN REACT? (Knowledge of prevention, spontaneous reference to condoms, right of women to protect themselves, initiating behavior change, barriers to prevention)
15. DOES THE WOMAN HAVE THE RIGHT TO ASK THE MAN TO USE CONDOMS? HOW CAN SHE ASK HIM? HOW WILL HE RESPOND?
- 15a. IF THE MAN DOES NOT WANT TO USE CONDOMS CAN THE WOMAN CONVINCE? HOW? (Empowerment, communication, male response, barriers)
16. IN GENERAL, ARE WOMEN WILLING TO USE CONDOMS? (Women's attitudes toward condoms, response of women to men who initiate condom use)
17. WHERE CAN A PERSON GET CONDOMS?
18. ARE WOMEN ABLE TO OBTAIN (BUY) CONDOMS ON THEIR OWN? (Condom availability, barriers to obtaining condoms)
19. WE HAVE HEARD THAT NOT ALL WOMEN HAVE THE RIGHT TO ASK A MAN TO USE CONDOMS. WHAT CAN YOU TELL US ABOUT THAT? (Types of women who have/do not have the right to demand condoms)
20. AS FAR AS YOU KNOW, ARE YOUNG PEOPLE IN THEIR TEENS IN DANGER OF CONTRACTING AIDS? WHY? (Beliefs about adolescent sexual behavior and AIDS risk)

21. HOW DO YOU THINK YOU MIGHT HELP YOUNG PEOPLE AVOID GETTING AIDS? (Responsibility of adults to counsel adolescents, appropriate advisors, nature of advice)
22. IF YOU KNEW THEY WERE SEXUALLY ACTIVE WOULD YOU ADVISE YOUNG PEOPLE TO USE CONDOMS? (Belief in the appropriateness of condoms for adolescents)
23. SOME PARENTS SAY THEY WOULD NOT TALK TO THEIR CHILDREN ABOUT SEX. WHAT DO YOU THINK ABOUT THAT? (Responsibility of parents for sex education)
24. (WOMEN ONLY) YOU WOMEN KNOW WHAT AIDS IS ABOUT. DO YOU BELIEVE YOU HAVE A RESPONSIBILITY TO PROTECT YOURSELVES? (Responsibility for prevention, risk of perinatal transmission) TO PROTECT YOUR UNBORN BABIES? PLEASE EXPLAIN WHAT YOU MEAN.
25. (WOMEN ONLY) HOW DO YOU THINK WOMEN MIGHT HELP EACH OTHER TO BE STRONGER IN THEIR RELATIONSHIPS WITH MEN? (Mutual support for protection against AIDS, sense of collective responsibility)
26. (MEN ONLY) YOU MEN KNOW WHAT AIDS IS ABOUT. DO YOU FEEL THAT YOU HAVE A RESPONSIBILITY TO PROTECT YOUR WIVES? (Responsibility for prevention, stable and casual partners) OTHER WOMEN THAT YOU MAY BE SEEING? YOURSELVES? PLEASE EXPLAIN.
27. AS FAR AS YOU KNOW, WOULD PEOPLE BENEFIT FROM TALKING ABOUT AIDS IN SMALL GROUPS LIKE THIS ONE? (Networking and support)